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Pepperdine University
Graduate School of Education and Psychology

QUALITATIVE ANALYSIS OF EMOTION REGULATION AS SEEN IN MIDDLE
EASTERN AMERICAN PSYCHOTHERAPY CLIENTS

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

by

Jennifer Nehme

June, 2018

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

This clinical dissertation, written by

Jennifer Nehme

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

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

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

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Kristen Leishman, Psy.D.

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VITA
JENNIFER NEHME

EDUCATION

- Pepperdine University (APA Accredited), Los Angeles, CA**
Doctor of Psychology in Clinical Psychology 2018
Dissertation Title: *Qualitative Analysis of Emotion Regulation as seen in Middle Eastern American Psychotherapy Clients*
Dissertation Chairperson: Susan Hall, J.D., Ph.D.
- Pepperdine University, Los Angeles, CA**
Master of Arts, Clinical Psychology with emphasis in Marriage and Family Therapy 2014
- Loyola Marymount University, Los Angeles, CA**
Bachelor of Arts in Spanish, with Honors 2005
Bachelor of Business Administration
- St. Louis University, Madrid, Spain**
Study Abroad Program 2003

CLINICAL EXPERIENCE

- Lucile Packard Children's Hospital at Stanford/Children's Health Council, Palo Alto, CA**
Predoctoral Psychology Intern 2017-2018
- Community Mental Health Rotation July 2017- December 2017
Children's Health Council (CHC) – Supervised by Lydia Flasher Ph.D. & Melanie Hsu, Ph.D.
- Provide individual and family psychotherapy within the Community Clinic (English & Spanish)
 - Administer cognitive, neuropsychological, social/emotional, and developmental testing to children and adolescents (English & Spanish)
 - Provide psychological testing feedback to families (English & Spanish)
 - Co-facilitate multifamily Dialectical Behavioral Therapy (DBT) skills group as part of CHC's Intensive Outpatient Psychotherapy (IOP) program
 - Participate in DBT consultation group with IOP's multidisciplinary team
 - Provide community outreach presentations to East Palo Alto high school staff assisting local students transitioning to college
 - Test battery [[See Appendix](#)]
- Pediatric Psychiatry Consultation-Liaison Rotation January 2018-March 2018
Lucile Packard Children's Hospital at Stanford – Supervised by Michelle Brown, Ph.D.
- Evaluate and provide short-term therapy to medically fragile patients and families in inpatient/outpatient pediatric clinics within Lucile Packard Children's Hospital at Stanford
 - Consult with medical team regarding emotional and behavioral impact of medical illness or hospitalization

- Attend daily Consultation-Liaison Rounds and weekly Consultation-Liaison Seminar

Comprehensive Care Program - Eating Disorders Rotation April 2018-June 2018

In-patient Eating Disorders Unit at El Camino Hospital – Supervised by Mary Sanders, Ph.D.

- Provide individual and family therapy to adolescents presenting with medical instability and malnutrition occurring within context of mental health conditions
- Consult with multidisciplinary team, milieu, and school staff
- Present cases at daily rounds
- Receive didactics focused on empirically-based treatments for eating disorders

CHOC Children’s Hospital of Orange County, Orange, CA

Bilingual Neuropsychology Extern – Supervised by Grace Mucci, Ph.D., ABPdN 2016-2017

- Administer neuropsychological tests for children and adolescents (ages 3-18)
- Assess, gather, and integrate critical behavioral observations affecting neuropsychological test performance
- Neuropsychological assessment experience includes conducting intakes, scoring and report writing, as well as treatment planning.
- Conduct case conceptualization based on findings from various neurocognitive domains (intelligence, language, memory, visual/motor, attention, academic function, and executive function)
- Attend and participate in weekly neuropsychology seminar and Neuro-Oncology Tumor Board meetings with interdisciplinary team of physicians, nurses, and social workers
- Provide neuropsychological screens at weekly Survivorship Oncology clinic, identifying children and adolescent survivors in need of neuropsychological evaluations, school-based interventions, and psychological support
- Assist families and caregivers in effectively advocating for services within school system critical to development of educational support services
- Participate in classroom observations
- Test battery [[See Appendix](#)]

Ventura Youth Correctional Facility, Camarillo, CA

Psychology Trainee – Supervised by James Morrison, Ph.D. 2015-2016

- Provide individual and group therapy to adolescents and young adults residing in the Division of Juvenile Justice
- Provide Cognitive and Dialectical Behavioral Therapy and Motivational Interviewing for predominantly gang-affiliated youth presenting with mood, disruptive, psychotic, and substance use disorders (ages 15-20)
- Monthly participation in didactics, grand rounds, and board hearings
- Collaborate with multidisciplinary team of professionals, including school psychologists, teachers, social workers, psychiatrists, and parole officers to assess youths’ progress
- Conduct, score, and interpret cognitive and personality assessments
- Test battery [[See Appendix](#)]

Sports Concussion Institute, Los Angeles, CA

Neuropsychology Extern – Supervised by Melissa Balderrama, Psy.D. 2015-2016

- Administer neuropsychological assessments to children, adolescents, and adults with closed head injuries, acute and chronic pain, balance disorders, memory and learning disorders, severe mental illness, and substance use disorders.

- Neuropsychological assessment experience includes scoring and report writing, as well as baseline and return-to-play evaluations.
- Administer baseline testing measures and provide concussion psychoeducation to high school and college athletes, in individual and group format.
- Test battery [[See Appendix](#)]

Pepperdine Community Counseling Center, Encino, CA

2014-2017

Psy.D. Trainee – Supervised by Anat Cohen, Ph.D. & Edward Shafranske, Ph.D., ABPP

- Provide psychotherapy for children and adults in various domains including mood, trauma, anxiety, substance abuse, personality disorders and acculturation difficulties.
- Participated in non-profit organization, *Children of the Night*, by providing individual psychotherapy to adolescents involved in sex-trafficking and sexual exploitation (ages 11-18)
- Provided therapy to children at Lanai Road Elementary School – Los Angeles Unified School District (ages 9-11)
- Conduct intake interviews and develop treatment goals with clients
- Test battery [[See Appendix](#)]

Valley Trauma Center, Van Nuys, CA

Sexual Assault and Child Abuse Prevention & Intervention Treatment Programs

2013-2014

Bilingual MFT Trainee – Supervised by Wendy Massey, M.S., LMFT

- Provide therapy to children, adolescents, and adults utilizing the Cognitive Processing Therapy (CPT) and Trauma-Focused CBT models
- Conduct intake interviews and crisis intervention
- Co-facilitated support group in Spanish for parents of child survivors of sexual assault
- Administer, score, and interpret Trauma Symptom Inventory (TSI) and Trauma Symptom Checklist for Children (TSCC)

Valley Trauma Center, Van Nuys, CA

Rape Crisis Advocate – Sexual Assault Services

2012-2013

- Provide survivors with emotional support and advocacy at local hospitals, law enforcement agencies, district attorney offices, court proceedings, and nurse forensic interviews
- Facilitate immediate response and crisis intervention to survivors of domestic violence, child abuse, rape, suicide, and parasuicide.
- Explore clients' legal issues, safety plans, counseling options, and potential shelter placement.

TEACHING EXPERIENCE

Teaching Assistant – Cognitive, Neuropsychological, and Emotional Assessment

Supervised by Carolyn Keatinge, Ph.D and Susan Himmelstein, Ph.D. 2015-2017

- Reviewing doctoral students' scoring of a range of cognitive, neuropsychological, and emotional assessment measures.
- Reviewing masters-level students' scoring and reports of a range of cognitive and emotional assessment measures.
- Administration of assessment labs for the MMPI-II, Rorschach, WAIS-IV and WISC-V.

SUPERVISORY EXPERIENCE

Trauma Recovery Center, Lynnwood, CA

Peer Supervisor, Supervised by LaTonya Wood, Ph.D. 2016-2017

- Provide peer supervision to first-year doctoral students working with adolescent and adult survivors of trauma and gang violence in hospital and school settings using the Attachment, Self-Regulation, and Competency (ARC) model
- Review and edit trainees' intakes and other clinical documents
- Review audio tapes of trainees' therapy sessions for instructional and educational purposes
- Facilitate support and processing of difficult emotional experiences related to trauma work

Valley Trauma Center, Van Nuys, CA

Advocate Supervisor– Sexual Assault Services 2013-2014

- Supervise rape crisis advocates via 24-hour support and resource line.
- Help facilitate advocates to process feelings related to difficult calls and crisis interventions.

RESEARCH EXPERIENCE

Pepperdine Applied Research Center (PARC), Los Angeles, CA

Positive Psychology Lab 2014-2017

PARC clinics coordinator & Research Assistant – Supervised by Susan Hall, J.D., Ph.D.

- Oversee research activities at Pepperdine's Encino, West L.A., and Irvine Community Clinics and Counseling Centers
- Organizing and synthesizing work on building and maintaining the research database
- Assisting with the research assistants' oversight and logistical details
- Fostering relationships with clinic staff and directors
- Raising awareness of Pepperdine Applied Research Center

Harbor-UCLA Medical Center, Torrance, CA

Adult Outpatient Psychiatry – CBT/DBT Clinic 2012-2014

Research Assistant – Supervised by Lynn McFarr, Ph.D.

- Gather and conduct research involving therapy interfering behaviors and secondary targets in Dialectical Behavioral Therapy, Cognitive Behavioral Therapy, and Acceptance and Commitment Therapy.
- Assisted and edited Dr. Lynn McFarr's chapter on Cultural Competency in DBT

- Conduct patient chart reviews identifying and screening for Post-Traumatic Stress Disorder and Trauma to identify risk of suicide and parasuicide among patients.
- Conduct patient chart reviews and screening psychiatric medication notes to identify DBT patients prescribed with Benzodiazepines.
- Implemented new database for DBT Diary Card data entry as well as conducting Diary Card data entry.
- Organize CBT/DBT clinic assessment measures for data entry into Excel and SPSS.

Pepperdine Applied Research Center (PARC), Los Angeles, CA

Positive Psychology Lab

2012-2017

Research Assistant – Supervised by Susan Hall, J.D., Ph.D.

- Conduct data entry using SPSS in order to further research on identify development in emerging adulthood.
- Research and review relevant literature and articles pertaining to therapist variables including race, ethnicity, theoretical orientation, and amount of training affecting treatment.
- Redact and prepare files for research data entry.

CONFERENCE PRESENTATIONS

Nehme, J., Hall, S. (2018, May). *Qualitative analysis of emotion regulation as seen in Middle Eastern American psychotherapy clients*. Poster to be presented at the thirtieth annual meeting of the Association for Psychological Science, San Francisco, CA.

Balderrama, M., **Nehme, J.** (2016, October). *Neurocognitive differences between monolingual and bilingual adolescents following sport-related concussion*. Poster presented at the thirty-sixth annual meeting of the National Academy of Neuropsychology, Seattle, WA.

Nehme, J., Naman, K., Wickremasinghe, N., Brown, L., Holler, R., Dexter, M., Forsyth, J., Bonfil, A., Fried, R., & McFarr, L. (2014, November). *Work outcomes in Dialectical Behavioral Therapy*. Poster presented at the forty-eighth annual meeting of the Association for Cognitive and Behavioral Therapies Conference, Philadelphia, PA.

Brown, L., Forsyth, J., Dexter, M., **Nehme, J., Naman, K., Wickremasinghe, N., Fried, R., Jackson, L., Morgan, W., & McFarr, L.** (2014, June). *Examining daily changes in self-harm, suicidality, and skills sse in DBT*. Poster presented at the 8th International Congress of Cognitive Psychotherapy, Hong Kong.

Gaona, L., Jackson, L., Counts, C., Morgan, W., **Nehme, J., Ramirez, U., & McFarr, L.** (2014, June). *Successful exposure treatment despite in-session mishaps: Case studies and practical interventions from clinical practice*. Poster presented at the 8th International Congress of Cognitive Psychotherapy, Hong Kong.

Argueta, N., Gaona, L., Jackson, L., Morgan, W., **Nehme, J., Ramirez, U., & McFarr, L.** (2014, June). *¡Lotería! An exploration of the use of cultural enhancements with an adult patient*

- in a Spanish-speaking DBT skills group at Harbor-UCLA AOP.* Poster presented at the 8th International Congress of Cognitive Psychotherapy, Hong Kong.
- Fried, R., Gaona, L., Jones, E., Brown, L., Jackson, L., Morgan, W., **Nehme, J.**, Naman, K., Dalton, E., Thompson, S., Davies, C., & McFarr, L. (2014, June). *Texting vs. calling in DBT skills coaching: An exploratory look at the frequency at Harbor UCLA Medical Center's adult outpatient psychiatry clinic DBT program: A case study.* Poster presented at the 8th International Congress of Cognitive Psychotherapy, Hong Kong.
- Waltman, S., **Nehme, J.**, Naman, K., Wickremasinghe, N., Brown, L., Morgan, W., Fried, R., Jackson, L., & McFarr, L. (2014, June). *Examining the relationship between case conceptualization and treatment fidelity of CBT in a public health setting.* Poster presented at the 8th International Congress of Cognitive Psychotherapy, Hong Kong.
- Waltman, S., Morgan, W., Wickremasinghe, N., Naman, K., **Nehme, J.**, Fried, R., Jackson, L., & McFarr, L. (2014, June). *Does fidelity of CBT in psychotherapy-based supervision translate to fidelity of CBT in clinical practice?* Poster presented at the 8th International Congress of Cognitive Psychotherapy, Hong Kong.
- Nehme, J.**, Naman, K., Wickremasinghe, N., Brown, L., Holler, R., Dexter, M., Forsyth, J., Bonfil, A., Fried, R., & McFarr, L. (2014, March). *Work outcomes in Dialectical Behavioral Therapy.* Poster session conducted at the Harbor-UCLA Scientific Sessions on Mental Health, Torrance, CA.
- Wickremasinghe, N., **Nehme, J.**, Naman, K., Brown, L., & McFarr, L. (2014, March). *The effect of ACT training on therapist levels of experiential avoidance.* Poster session conducted at the Harbor-UCLA Scientific Sessions on Mental Health, Torrance, CA.
- Naman, K., Wickremasinghe, N., **Nehme, J.**, Brown, L., & McFarr, L. (2014, March). *CBASP 1-Day training 2012 vs. 2013: Effect on therapist knowledge.* Poster session conducted at the Harbor-UCLA Scientific Sessions on Mental Health, Torrance, CA.
- Brown, L., Forsyth, J., McFarr, L., Dexter, M., Dour, H., **Nehme, J.**, Naman, K., & Wickremasinghe, N. (2013, November). *Changes in suicidality, self-harm, and affect in Dialectical Behavior Therapy: A preliminary analysis of self-report diary cards.* Poster presented at the forty-seventh annual meeting of the Association for Cognitive and Behavioral Therapies Conference, Nashville, TN.
- Gaona, L., Jackson, L., Fried, R., McFarr, L., Graling, K., Dour, H., Brown, L., Holler, R., Wickremasinghe, N., Naman, K., & **Nehme, J.** (2013, November). *Clinicians' self-perception of dialectical thinking: Pre and post DBT training.* Poster presented at the annual meeting of the International Society for Improvement and Teaching of Dialectical Behavior Therapy, Nashville, TN.
- J. Snyder, L.L.Jackson, **J. Nehme**, N. Wickremasinghe, & L. M. McFarr, Ph.D. (2013, January). *From Pills to Skills: Does engagement in DBT correlate with a decrease in*

benzodiazepine prescriptions? Poster session conducted at the Harbor-UCLA Scientific Sessions on Mental Health, Torrance, CA.

L.L. Jackson, **J. Nehme**, N. Wickremasinghe, K. Naman, K. Maczka, J. Snyder, & L.M. McFarr. (2013, January). *The co-occurrence Of BPD and PTSD: Barriers to diagnosis of PTSD among clinicians In community mental health*. Poster session conducted at the Harbor-UCLA Scientific Sessions on Mental Health, Torrance, CA.

Barr, N. U., Dour, H. J., Benson, L. A., **Nehme, J.R.**, & McFarr, L. (2012, November). *Perceived competence as a potential mediator of DBT knowledge and attitudinal change in clinicians treating borderline personality disorder*. Poster presented at the annual meeting of the International Society for Improvement and Teaching of Dialectical Behavior Therapy. National Harbor, MD.

Nehme, Jennifer. (2004). "Poverty and Racism in the Poetry of Cuban writer Nicolás Guillén" Southern California Council of Undergraduate Research, Whittier, CA.

ADDITIONAL CLINICAL TRAINING

- **Harbor-UCLA Medical Center, Los Angeles Department of Mental Health**
Ten-month course in the advanced theory and application of CBT
Advances in Cognitive Behavioral Therapy (CBT) 2013-2014
- **Harbor-UCLA Medical Center, Los Angeles Department of Mental Health**
Dialectical Behavioral Therapy (DBT) Two-Day Training, Lynn McFarr, PhD 2013
- **Harbor-UCLA Medical Center, Los Angeles Department of Mental Health**
Acceptance and Commitment Training (ACT) Training, Robyn Walser, PhD 2013
- **Harbor-UCLA Medical Center, Los Angeles Department of Mental Health**
Cognitive Behavioral Analysis Systems of Psychotherapy (CBASP), Eric Levander, M.D. & Lynn McFarr, Ph.D. 2013
- **California Governor's Office of Emergency Services (Cal-OES)**
Sexual Assault Counselor State Certification (Advocate) 2012

PROFESSIONAL ASSOCIATIONS

Association of Psychological Science	2018-Present
Research and Practice Team, Member and Co-Leader	2012-2017
Psi Chi, The International Honor Society in Psychology	2012-2017
Sigma Delta Pi, Spanish Honor Society	2002-2004
Dean's List, Loyola Marymount University	2002-2004

ABSTRACT

Middle Eastern individuals represent a heterogeneous group comprised of different nationalities, languages, and religious identifications. Yet, Middle Eastern Americans are widely underrepresented in the psychotherapy literature. Extant literature appears to focus on professional opinions about what psychotherapists should do when working with this population, including understanding cultural factors, such as incorporating family in treatment and acculturation status. Considering cultural communication patterns among this population, emotion is generally understood to be inhibited or suppressed, as disclosing personal problems and expressing emotion outside the family sphere can be viewed as disloyal and/or shaming. Thus, one of the many areas mental health clinicians should consider when working with Middle Eastern clients is how to recognize emotional communication patterns and identify and assist their clients with emotion regulation and/or dysregulation in a culturally sensitive manner.

To address the need for research on how emotions are expressed and regulated in psychotherapy with Middle Eastern clients, this study qualitatively analyzed three psychotherapy cases from a university's community counseling center's archival research database. More specifically, the researchers used an inductive content analysis approach with emotion, emotion regulation and InVivo codes to observe themes of emotional expression, regulation and dysregulation that emerged from the gathered data from a course of psychotherapy with these Middle Eastern American clients to further classify the observable phenomena (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005; Saldaña, 2009; Weber, 1990).

Consistent with previous literature, results indicated that negative emotions were coded more frequently in psychotherapy sessions than positive emotions, as was the emotional regulation strategy of *Experiential Avoidance*. Surprisingly, data emerged revealing positive

emotion regulation strategies (e.g., acceptance and emotional identification) that were not identified by literature describing this population. By obtaining a better understanding of how Middle Eastern American clients expressed and utilized their emotions in treatment, this study may be useful to the future work of clinicians and researchers targeting treatment of these individuals in a culturally sensitive manner and in an approach that emphasizes positive emotion regulation strategies.

Chapter 1: The Problem

Introduction

Middle Eastern individuals represent a heterogeneous group comprised of different nationalities, languages, and religious identifications. Individuals from the Middle East are one of the fastest growing ethnic minority groups in the United States (Camarota, 2012; Pew Research Center, 2011). Immigration to the United States from the Middle East occurred in several waves: in the early 1900s, mid to late twentieth century, and in the present day as a result of civil wars, dispossession of land, violence, and political unrest (Hilliard, Ernst, Gray, Saeed, & Cortina 2012).

Given the history of immigration to the United States since the early 1900s, different levels of acculturation across generations of Middle Eastern Americans exist, adding to the complexity and heterogeneity of this cultural group (Hilliard et al., 2012). Immigration difficulties, acculturative stress, posttraumatic stress as a result of trauma, as well as intergenerational and family dynamics are common complexities experienced by this cultural group in the United States (Nassar-McMillan & Hakim-Larson, 2003; Salem & Flaskerud, 2011). Discrimination, prejudice, and violence towards Middle Eastern communities following the attacks on September 11, 2001, have also contributed to psychological distress, decreased levels of happiness, and health-related concerns (Padela & Heisler, 2010). These factors, including unique within group issues, reveal wide implications for mental health clinicians working with this population as of the need for mental health services in the United States grows.

Background of Problem

Despite the growing need for mental health services, Middle Eastern Americans are widely underrepresented in the psychotherapy literature. The U.S. Census Bureau (2017)

categorizes Middle Eastern Americans as Caucasian. Abdulla and Brown (2011) argue that this is a miscategorization in light of the diversity encompassing this cultural group, which may underrepresent this group in the research. For instance, because Middle Eastern Americans are typically labeled as Caucasian, within studies examining mental health, Middle Eastern Americans and Caucasians are not examined distinctly; thus, results may potentially be misleading (Abdulla & Brown, 2011; Soheilian & Inman, 2009).

Further, the literature that exists appears to focus on professional opinions and theories about what psychotherapists should do when working with this population. These opinions and theories include understanding salient cultural factors, such as the need to involve family in treatment and acculturation status (Abdulla & Brown, 2011; Erickson & Al-Timimi, 2001; Haboush, 2007; Martin, 2014; Nobles & Sciarra, 2000).

When looking at this literature considering cultural communication patterns among this population, emotion is generally understood to be inhibited or suppressed, as disclosing personal problems and expressing emotion to an individual outside of the family sphere can be experienced as disloyal and/or shaming (Abdulla & Brown, 2011; Al-Krenawi & Graham, 2000; Dwairy & Van Sickle, 1996; Haboush, 2005). Generally speaking, for many individuals seeking mental health services, one of the overarching goals of psychotherapy is to facilitate recognition of one's own emotion, and to explore the ways in which the individual regulates his or her emotions (Berking et al., 2008; J. R. Schore & Schore, 2014).

Although the American Psychological Association provides guidelines for developing and implementing cultural competency in practice, these guidelines are minimum standards and do not provide specific suggestions for working with individuals of Middle Eastern descent. (APA, 2003). In fact, these guidelines refer to individuals of ethnic and racial minority groups as

belonging to Asian and Pacific Islander, African-American (sub-Saharan), Latino and Hispanic, and Native American descent (APA, 2003); this researcher observed that, in doing so, these guidelines effectively omitted specific considerations for working with Middle Eastern Americans. Further adding to limited information on how to disseminate mental health services among Middle Eastern Americans (Soheilian & Inman, 2015), a review of the literature for this dissertation revealed that no research appears to have been conducted that explores how emotions are shared and/or dealt with by Middle Eastern clients in psychotherapy. Thus, one of the many areas mental health clinicians should consider when working with Middle Eastern clients is how to recognize emotional communication patterns and identify and assist their clients with emotion regulation and/or dysregulation in a culturally sensitive manner, which this study sought to examine.

Purpose and Importance of the Study

The current dissertation aimed to examine specific verbal expressions of emotions, emotional regulation and/or dysregulation as experienced by psychotherapy clients of Middle Eastern descent. Gaining a better understanding of how emotions and emotional regulation is exhibited or struggled with by Middle Eastern individuals can redress the lack of literature on assessment and psychotherapy with this population.

Such work may also be used to inform recommendations for clinicians treating these individuals, and researchers exploring cultural variables within this population that may inform treatment. Given the lack of research on Middle Eastern psychotherapy clients, identifying themes and patterns related to the process of emotional regulation or dysregulation in real sessions can alert and guide clinicians and researchers to form future research questions about how to formulate interventions tailored to focusing on culturally sensitive emotion regulation

skills. As only few assessment measures of emotion and emotional regulation have been specifically adapted for use or studied with this population, research based on actual sessions with Middle Eastern psychotherapy clients can also inform how current measures are used or should be modified, and whether there is a need to create new assessment measures to advance treatment services.

This dissertation was a qualitative analysis of how emotion regulation was verbally expressed among individuals of Middle Eastern descent in the therapeutic setting. In consideration of cultural and systemic factors, the purpose of this study was to identify themes related to emotion, specifically how emotion was regulated and/or dysregulated during actual psychotherapy sessions, in order to inform factors for clinicians to be aware of when working with these individuals and to inform future assessment and treatment research.

Research Questions

The research questions for this study were: (a) How are emotions expressed by Middle Eastern Americans in psychotherapy?, and (b) How are emotions regulated by Middle Eastern Americans in psychotherapy?

Clarification of Terms

Middle East and Middle Eastern. Within the literature, Middle Eastern, Arab, and Muslim are often used interchangeable and inconsistently. For the purposes of this study, Middle Eastern Americans represent individuals living in the United States who identify with ethnic heritage of the following Middle Eastern countries: Egypt, the Arab countries of Asia (Bahrain, Iraq, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syria, United Arab Emirates, Yemen), Israel, Afghanistan, Turkey, and Iran (Sayyedi, Alshugairi, & Azar-Salem, 2011). The terms Middle Eastern and Middle Eastern American are used throughout this

dissertation. The term Middle Eastern is used to specifically refer to individuals from Middle Eastern countries as well as more generally referring to both Middle Eastern and Middle Eastern Americans. Because the client-participants in this study identified with the ethnic heritage of Iran, they are often referred to in this study as Middle Eastern Americans.

Iranian and Persian. The terms Iranian and Persian are often used interchangeably to refer to individuals and descendants of Iran; however, debate among members of this population exists regarding the use of either term (Mobasher, 2006). For many individuals of Iranian/Persian descent, preference for use of either term hinders on several factors, including cultural, religious, and political identities (Mobasher, 2006). As the debate between terms is rooted in factors beyond the scope of this study, for the purposes of this study, the terms Iranian and Persian were used interchangeably. The client-participants described in this study identified as Iranian, Persian and Romanian, and Persian and Israeli.

Emotion regulation and dysregulation. Within the literature, many constructs of emotion regulation appear to be differentiated. For example, affect regulation is often used as an umbrella term to describe emotion regulation, mood regulation, and coping. (Gross, 2015a). Because these constructs appear to overlap in practice, for the purposes of this dissertation, emotion regulation was used as an overarching term to encompass mood regulation, affect regulation, and coping. Where noted, emotion dysregulation referred to how an individual exhibited difficulty with regulating his or her emotions. Further clarification of these terms is provided in the Review of Relevant Literature.

Chapter 2: Review of Relevant Literature

Overview

Current literature on emotion and emotion regulation is well established. However, current research focused on how Middle Eastern Americans express and regulate emotions in the psychotherapy setting is limited. Further, while literature on cultural identities of Middle Eastern Americans exists within the psychological literature, a lack of empirical data exists regarding specific treatment interventions and practices that are culturally adapted to this group. Thus, this review of the literature begins with a presentation of the definitions, models, and assessment of emotion, emotion regulation, and emotion dysregulation. Next, the literature on Middle Eastern cultural identities, communication and emotional expression, presenting issues in psychotherapy, and treatment recommendations are reviewed and critiqued, followed by a summary of this chapter.

Current Status of Theory and Research on Emotion and Emotion Regulation

Emotional expression and emotion regulation has garnered interest among scholars, philosophers, and theologians dating back centuries. Managing feelings and anxiety, as well as the degree to which we are able to control our emotions, have been the essential focus of some of the most noteworthy works of history, such as self-regulation in Plato's *The Republic* (Gross, 2015a). The study of emotion regulation within the modern era of psychology was initially examined via psychological defenses (Freud, 1926/1959), which paved the way to our understanding of attachment (Bowlby, 1969).

More recently, the study of emotion regulation within the field of psychology has flourished in the past two decades (Gross, 2007, 2010). According to Gross and Barrett (2011), there has been a 150-fold plus increase in citations over the past 15 years containing the words

“emotion regulation.” Emotion regulation is currently being studied among the major sub-areas of psychology: biological, cognitive, developmental, social, industrial organizational, personality, clinical, and health (Gross, 2015b). Due to the surge of research on emotion regulation in the field of clinical psychology, confusion surrounds its definition; thus, clarification of the terms emotion and emotion regulation is indicated (Buck, 1990; Gross, 2015a). This section, therefore, begins with an introduction to definitions of emotion and various models of emotion, and is followed by an elaboration of the definitions and models of emotion regulation and emotion dysregulation.

Definitions and Models of Emotion

The models chosen for review in this study represent widely established models of emotion regulation, which have been reviewed to illustrate broad perspectives on emotion and emotion regulation. Some of these specific models were also used to assist researchers during analysis. For instance, Linehan’s Biosocial Model of emotion regulation was frequently used during coding and analysis as this model focuses on cultural factors and the impact of culture on emotion regulation. Additionally, the appraisal model of emotion also influenced and informed researchers during the study, as it holds the view that appraisal of emotions may be influenced by cultural factors, and that similar events can hold different emotions for different individuals (Ellsworth, 2013).

Emotion definition. A concise definition of *emotion* is lacking, due to many unclear definitions and a lack of empirical research based on animal models. Yet, despite the broad range in definitions and approaches, definitions of emotions contain three characteristics that are evident across approaches. First, emotions are said to involve changes in subjective experience, behavior, and physiology (Mauss, McCarter, Levenson, Wilhelm, & Gross, 2005), second, they

unfold over time (Cunningham & Zelazo, 2007), and third, they can be adaptive or maladaptive (Gross, 2015a).

Regarding the first characteristic, emotions are affective reactions, either positive or negative, to specific states (Gendolla, 2000; Gross, 2015a), which involve psychological, physiological, and behavioral changes. Thus, Russell and Barrett (1999) referred to emotion as a “complex set of interrelated sub-events concerned with a specific object” (p. 806). Within this characteristic, however, it is important to clarify the differences between emotion, core affect, and mood, as these constructs are often used interchangeably. According to Russell (2003), core affect is “primitive, universal, and simple (irreducible on the mental plane). It can exist without being labeled, interpreted, or attributed to any cause” (p. 148). Barrett, Mesquita, Ochsner, and Gross (2007) simply refer to core affect as a representation of emotion as either pleasure or displeasure. Similarly, Gross (2015a) describes the valuation of core affect as a “good for me” (p. 2) versus “bad for me” (p. 2) discernment. Mood, on the other hand, typically lasts longer than emotions (Ekkekakis, 2012). Frijda (2009) offers an additional view, stating that moods can be specific or highly generalized. Further, stress responses refer to difficulties or challenges faced managing situational demands, whereas moods are diffuse affective states that are experienced subjectively for longer periods of time (Gendolla, 2000).

Second, definitions of emotion often describe emotional processes, including how emotions are generated and unfold over time. For example, according to Cozolino and Siegal (2009) emotions are at the forefront of perceptual and cognitive processes. Cozolino and Siegal (2009) outlined emotion as a primary value system of the brain whereby activations occur in stages. At the first stage, emotion evokes attentional mechanisms on the stimulus. Secondly, appraisal mechanisms assess the hedonic nature of the emotion (e.g., “Am I safe” or “Am I in

danger?”). Thirdly, the appraisal method is elaborated further into categorical emotion (e.g., happiness, fear, anger, sadness), which generally have universal facial expressions (Cozolino & Siegal, 2009). Facial expressions are viewed as emotional responses to a situation, memory, or mental image (Ekman, 1992). Specific facial expressions of emotions are considered universal, which include expressions of hatred, shame, guilt, and interest (Ekman, 1992).

Similarly, a generative process is outlined by Gross, Sheppes, and Urry (2011a), in which emotions are generated by an individual during a situation that requires attention, in which the specific situation produces a specific meaning to the individual, and produces a multi-system response to the ongoing person-situation transaction. Akin to Cozolino and Siegal’s (2009) view, this process, according to Gross, is a system where emotions are produced in series of stages: attending to the situation, generating meaning to the situation, and producing experiential, behavioral, and physiological responses (Gross 1998, 2001, 2002).

Third, emotions serve specific functions, which can be adaptive or maladaptive, depending on context (Gross, 2015a). With respect to adaptive functioning, emotions guide our decision-making (H. A. Simon, 1967); for example, the experience of fear can prevent us from entering into dangerous situations. Anger can be adaptive in that it can propel individuals into inspiring change and creating social justice. Happiness can foster social interactions, kindle love, and form new interpersonal connections. On the other hand, emotions can be maladaptive when they are used incongruently with a particular situation, or are of the “wrong intensity, duration, and frequency...and maladaptively bias cognition and behavior” (Gross, 2015a, p. 4). Examples include anger that may lead to self-injurious, suicidal, or homicidal behavior and fear that leads to excessive worry, which negatively affects an individual across multiple daily situations.

Emotion models. There have been various psychological approaches to the study of emotion, including basic emotion, appraisal, psychological construction, and social construction models. First, basic emotion approaches (e.g., Ekman, 1972; LeDoux, 2009) postulate that emotions such as “anger,” “sadness,” and “fear” produce unique mental states, caused by a specific brain mechanism, which thus lead to unique behavioral responses, including response tendencies and biological responses (Gross & Barrett, 2011).

Second, the appraisal perspectives on emotion (e.g., Lazarus, 1991; Leventhal, 1982) also state that emotion words produce unique mental states; however, according to appraisal theorists, these words do not always name distinct mental mechanisms (Gross & Barrett, 2011). Where emotions are viewed as universal to emotion theorists, appraisal theorists consider appraisals to be universal. Ekkekakis (2012) simply refers to appraisals as cognitive evaluations of the meaning and the stimulus of the emotion, and are always involved during a transaction between person and object. Further, appraisal theorists believe that an individual’s appraisal of an event is influenced by that individual’s culture, environment, biology, goals, and life experiences; as such, the same event can provoke a different emotional response among different individuals (Ellsworth, 2013). Therefore, this understanding is relevant to the understanding of how Middle Eastern individuals express and/or regulate their emotions as it takes into context biological, cultural, environmental, and individual factors.

Third, psychological construction models (e.g., Barrett & Bliss-Moreau, 2009; Wundt, 1897/1998) posit that emotions are not unique mental states and are not caused by specific brain mechanisms. Rather, emotions are continually modified and evolving over time. As such, they are considered by some construction theorists to be “emergent products of psychological ingredients” (Gross & Barrett, 2011, p. 11).

Lastly, social construction models (Harré, 1986; Solomon, 2003) view emotions as generated by sociocultural factors and formed via culturally-specified roles within the social context (Gross & Barrett, 2011). Other social construction theorists view emotions as being endorsed by individuals instead of by nature (Gross & Barrett, 2011).

Although each of the aforementioned emotion models are well-represented in the field, those including appraisal and reappraisal mechanisms and social construction models appear specifically emphasize cultural factors in the understanding of emotions. As such, these models were seen as more pertinent to the focus of study and population of interest in this dissertation, which focused on emotion regulation in Middle Eastern American psychotherapy clients. The following section highlights the research on emotion regulation models, and cultural differences of the interpersonal effects of emotion based on sociocultural values.

Emotion Regulation

Emotion regulation is a fast growing area within the scientific study of psychology. As a result, several definitions and perspectives of emotion regulation exist, including sociocultural (Matsumoto, Yoo, & Nakagawa, 2008) and neurological (Beauregard, Lévesque, & Bourgoin, 2001; A. N. Schore, 1994) bases of emotion regulation. Further, models of emotion regulation that focus on early development (Cole, Martin, & Dennis, 2004) as well as adults (Gross, 2015a) exist within the current literature. Still other models of emotion regulation focus on individual differences in emotion regulation, such as Bonanno and Burton's (2013) construct of *regulatory flexibility*, which assumes the *fallacy of uniform efficacy* and takes into considerations individual differences in "sensitivity to context, availability of a diverse repertoire of regulatory strategies, and responsiveness to feedback" (p. 591).

Because the proposed dissertation study focuses on the ways in which Middle Eastern American adults regulate emotions in psychotherapy, this section first focuses on adult definitions of emotional regulation and related constructs, and then models that address such action aspects of emotional regulation and those that come from psychotherapy literature (e.g., Blackledge & Hayes, 2001; Gross, 2015b; Linehan, 1993; Ma, Tamir, & Miyamoto, 2018; Tamir et al., 2016). Culturally sensitive models, including Linehan's Biosocial model of emotion regulation, Acceptance and Commitment Therapy, the Instrumental Approach, and the Extended Process Model of Emotion Regulation helped to inform the researcher's understanding of emotion regulation during coding and analysis as they provided a broad and encompassing view of biological, social, and psychological factors.

Defining emotional regulation and related constructs. Gross, a pioneer in the study of emotion regulation, defined emotion regulation as the activation of a goal that recruits one or more processes to influence emotion generation (Gross et al., 2011a, 2011b). It is also loosely referred to the things humans do to influence the emotions they have, when they have them, and how they are experienced and expressed (Gross, 1998). Emotion regulation may be unconscious or conscious (automatic or controlled) utilized to increase, maintain, or decrease one or more components of an emotional response, such as feelings, behaviors, and physiological responses (Eftekhari, Zoellner, & Vigil, 2009; Gross, 1999).

An individual's goal to regulate his or her emotions is referred to by Gross (2015a) as *intrinsic emotion regulation*, whereas the goal to regulate others' emotions is referred to as *extrinsic emotion regulation*. In other words, this regulatory goal either induces a change in the individual experiencing the emotion (intrinsic) or to engender emotional change in another

individual (extrinsic; e.g., a mother soothing her crying child; Macklem, 2008; Sheppes, Suri, & Gross, 2015).

Emotion regulation can be distinguished from emotion generation by the processes that generate an emotion in a particular situation and the processes used to influence current or future emotions (Gross et al., 2011a). Emotion generation and emotion regulation are similar in that both are goal-directed; however, emotion regulation only occurs in pursuit of a goal to influence an ongoing or future emotion (Gross et al., 2011a). According to Gross et al., (2011a), the target of an emotion regulation goal is always the emotion-generative process and the target of an emotion-generation goal is the internal or external environment.

There are other constructs related to emotional regulation that may be differentiated. Akin to the term *affect* encompassing various affective states, the term *affect regulation* may also be considered an umbrella term that incorporates mood regulation, coping, and emotion regulation (Gross, 2015a). Mood regulation can be understood as the process by which the individual attempts to alter subjective feeling states (Larsen, 2000). Coping refers to the ability to deal effectively with difficult, temporal situations (Gross, 2015a). More specifically, coping is related to emotion in that it is a regulatory process where the individual attempts to “deal with the emotional experience, expression, and physiological reactions [while coordinating] motor behavior, cognition, attention, and reactions from the social and physical environments” (Skinner & Zimmer-Gembeck, 2007, p. 123).

An influencing force in the field of emotion and emotion regulation, Gross (2015a) discerns emotion regulation from mood regulation and coping, with emotion regulation being “the activation of a goal to influence the emotion trajectory” (p. 5). In other words emotion regulation utilizes goal-directed actions to activate specific emotions; whereas coping utilizes

cognitive and behavioral efforts (e.g., problem-focused or emotion-focused) to attenuate specific experiences (Lazarus & Folkman, 1984). Although different constructs of emotion regulation appear to be differentiated in the literature, such constructs appear to overlap in practice. For example, a goal-directed action (e.g., emotion regulation), may not significantly differentiated from a behavioral effort or action (e.g., coping). Further, in practice, there lies difficulty in parsing out the differences between activation of specific emotion or altering an emotional trajectory (e.g., emotion regulation), attenuating specific experiences (e.g., coping), or feelings (e.g., mood regulation).

Cultural differences exist regarding the interpersonal effects of emotion regulation based on cultural values (Matsumoto et al., 2008). Due to the developmental context of the individual, the ability to regulate emotion, either by regulating the expression of emotion or by inhibiting emotion, is learned (Bell & Calkins, 2000; A. L. Miller, McDonough, Rosenblum, & Sameroff, 2002; Volling, McElwain, & Miller, 2002). Emotions, as mentioned earlier, can serve adaptive social functions and can motivate individuals to perform certain behaviors, such as communicating one's internal emotional states and galvanizing others to behave in pro-social ways. Different cultures have distinct set of norms and values relating to emotion regulation, given that emotions serve as primary motivators of behavior, have important social functions, and maintain social order (Keltner, Ekman, Gonzaga, & Beer, 2003; Matsumoto et al., 2008).

Emotion regulation models. This subsection describes some researched models of emotion regulation selected by the researcher as they are both widely established in the literature and they incorporate cultural factors in the understanding of emotion regulation. It begins with Gross' Extended Process Model, a thoroughly outlined model of emotion regulation and followed by the Instrumental Approach. Further, treatment models of emotion regulation are

described in this section, namely Linehan's Biosocial theory from Dialectical Behavioral Therapy and Hayes' Acceptance and Commitment Therapy, as they highlight how the inhibition of emotion is a result of emotion dysregulation. As will be noted in a subsequent section, the inhibition of emotion is characteristic of Middle Eastern culture; therefore, therapy models that address the inhibition of emotion can provide potential treatment options when working with this population.

Extended process model of emotion. The Extended Process Model of Emotion Regulation is based on the assumption that individuals value and discern affect as "good for me" (p. 2) versus "bad for me" (Gross, 2015a, p. 2). In other words, "valuation involves the juxtaposition of a representation of the world with a representation of a desired state of the world" (Gross, 2015a, p. 10). Given that individuals hold different values and belief systems, people experience emotions based on the interactions and operations of different valuation systems (Gross, 2015b; Sheppes et al., 2015).

Further, Gross's model identifies stage-based emotion-regulation strategies (Gross & Thompson, 2007). In each of these sequential stages, various aspects of emotion regulation are involved: "(1) selection of the situation, (2) modification of the situation, (3) deployment of attention, (4) change of cognitions, and (5) modulation of the experiential, behavioral, or physiological responses" (Gross & John, 2003, p. 349). The first stage, termed selection of the situation, occurs prior to the situation that causes an emotional reaction where the individual selects a specific situation; in the second stage, modification of the situation, the individual attempts to change certain aspects of the emotionally provoking situation; in the third stage, the individual's attention is elicited to the stimulus; in the fourth stage, the individual attempts to use cognitive reappraisal to change the way he/she interprets the situation; lastly, in the fifth stage,

the individual attempts to change the degree or effect of his/her emotional response (Gross & Thompson, 2007). Of relevance to psychotherapy, as well as to the current dissertation study, *cognitive reappraisal*, a form of cognitive change, refers to how individuals interpret or understand an emotion-stimulating situation to alter its effect on the individual's emotional experience. Additionally, *suppression*, a form of response modulation, is referred to as the inhibition of emotional experience or emotionally expressive behavior (Gross, 1998; Gross & John, 2003).

With respect to cultural differences in emotion regulation, Matsumoto et al. (2008) proposed that differences in values orientations are associated with differences in emotion-regulation norms. Specifically, they suggested that cultures that value *Individualism*, *Egalitarianism*, and *Affective Autonomy*, utilize Reappraisal and less Suppression of emotional experience, given the value placed on emotion and emotional expression (Matsumoto et al., 2008). Cultures emphasizing *Power Distance*, *Embeddedness*, and *Hierarchy*, utilize less Reappraisal and have a tendency to value Suppression, given the decreased emphasis on emotions and the necessity to suppress emotions for the greater good of the family unit or the community (Matsumoto et al., 2008). Recent research supports that for interdependent cultures that emphasize social harmony, emotional suppression is considered normative and well-practiced (e.g., Sun & Lau, 2018). Middle-Eastern cultures typically value *Power Distance*, *Embeddedness*, and *Hierarchy*; thus, this study aims to possibly identify the ways in which Middle Eastern American individuals suppress or reappraise their emotions during the process of psychotherapy.

In sum, the Extended Process Model of Emotion regulation illustrates the stages of Emotion Regulation and the process by which emotions result from operations of valuation

systems (Gross, 2015b). Also, this model recognizes that differences in specific values affect how emotion is regulated across various cultures (Gross & John, 2003). With respect to use in psychotherapy, Gross' modal model of Emotion Regulation has been utilized in the research of emotion regulation among individuals with Autism Spectrum Disorder (ASD), as these individuals typically present with poor regulatory capacities (Weiss, Thomson, & Chan, 2014). In terms of assessment, *Emotion Regulation Questionnaire* (ERQ; Gross & John, 2003) appears to be widely used in the assessment of emotion regulation, purports to assess individual differences in reappraisal and suppression, and can be used to study various cultural groups (Gross & John, 2003). The ERQ is further discussed in the assessment section.

Instrumental approach. The instrumental account of emotion regulation states that individuals seek to maximize utility as well as pleasure when choosing what emotions they want to feel (Tamir, 2009). Furthermore, this model posits that people seek to feel specific emotions based on their cultural values because this goal-directed process would result in benefits to them (Ma et al., 2018; Tamir et al., 2016).

According to this model, immediate benefits are considered to be in forms of immediate pleasure or gratification, and long-term benefits constitute delayed gratification in pursuit of a goal. When immediate benefits outweigh long-term benefits, individuals prefer to experience pleasant emotions; however, when long-term benefits outweigh immediate gratification, individuals should prefer useful emotions (Tamir, 2009). In other words, instrumental goals, which aim to delay reinforcement, are pursued when maximum utility is desired (Mischel, Shoda, & Rodriguez, 1989). When determining utility and pleasure, this model notes how beliefs and attitudes about emotion are influenced by cultural variances in emotion regulation (Ma et al., 2018). Thus, individuals choose either immediate or long-term benefits depending on the

ultimate goal pursued, and the utility of behaviors is dependent upon the goals pursued by the individual (Tamir, 2009). For example, an individual may forego immediate pleasure by dieting and exercising in order to pursue weight loss. The instrumental account highlights that while unpleasant emotions are not favorable, individuals will experience them in pursuit of a goal that can only be attained by experiencing unpleasant emotions (Tamir, 2009).

When considering implications for psychotherapy, it is unclear as to how widely the model is used and there is no indication that any assessment measures were developed from this model. Only two studies appeared to have recently been conducted to test Tamir's Instrumental model. In the first, the frequency, consistency, and predictors of emotion regulation were assessed in a sample of 114 adult participants using diaries to journal their use of instrumental and negative emotion goals in their most negative event of the day (Kaloerinos, Tamir, & Kuppens, 2017). Although this study's findings supported instrumental goals in the regulation of negative emotions, it did not address positive emotion regulation (Kaloerinos et al., 2017).

In the second recent report examining sociocultural differences utilizing the instrumental approach, four separate studies using samples of European Americans, Japanese, and a broader Asian sample, revealed that positive emotion regulation strategies differed based on cultural backgrounds and situations (Ma et al., 2018). The first study found that European-American participants endorsed a higher utility for positive emotions than the Japanese sample; the second study revealed cultural differences in the preference for positive emotions depending on the cognitive effort required for task (e.g., Americans endorsed strong preference for positive emotions when the context required strong cognitive effort); the third study found that the American sample revealed a stronger preference to relish positive emotions in the face of a high cognitive effort task than the Asian sample; and the fourth study also indicated that the American

sample tended to appreciate positive emotions in the face of a high-cognition task, and that differences in emotion regulation was marginal when both samples were faced with a neutral task (Ma et al., 2018).

Linehan's biosocial model. Linehan's (1993) Dialectical Behavioral Therapy (DBT) is a third wave psychotherapy that targets emotional dysregulation through emotional regulation strategies, among others. DBT conceptualizes/explains emotional dysregulation through its foundation on the biosocial theory of personality functioning, which "results from biological irregularities combined with certain dysfunctional environments, as well as from their interaction and transaction over time" (p. 42).

DBT is also founded on behavioral theory as well as dialectical theory, which combined encompass the fundamental nature of reality and that of persuasive dialogue and relationship that the therapist utilizes in order to co-create change (Linehan, 1993). Dialectics assumes an "interrelatedness or wholeness of reality [that emphasizes] the immediate and larger context of behavior, as well as to the interrelatedness of individual behavior patterns" (Linehan, 1993, p. 1).

Emotional dysregulation. DBT was originally developed for the treatment of Borderline Personality Disorder (BPD), which Linehan asserts is the result of a dysfunction of the emotion regulation system. Emotion dysregulation develops as a result of high emotional vulnerability as a result of biological and environmental sources, coupled with difficulties regulating emotions (Linehan, 1993). More specifically, biosocial theory describes how "invalidating environments in childhood...fail to teach the child how to label and regulate arousal, how to tolerate emotional distress, and when to trust her own emotional responses as reflections of valid interpretations of events" (Linehan, 1993, p. 42). As adults, individuals who have been invalidated throughout their lives have learned to leave the invalidating environment, change their behavior to meet the

demands of the environment, or attempt to make themselves valid in order to reduce the environmental validation (Linehan, 1993). Individuals with emotion regulation deficits struggle with modulating their emotions, as inhibition, escape, and avoidance have been learned and reinforced over time, effectively increasing their emotional reactivity.

Of the many approaches to studying emotion dysregulation in BPD, Carpenter and Trull (2013) supported Gross' model of emotion regulation, in which emotion dysregulation can be understood as a process involving multiple components and not as a distinct mental state (Werner & Gross, 2010). The components of emotion dysregulation can be viewed as: emotional vulnerability (made up of emotion sensitivity and heightened and labile negative affect) and lack of skills to regulate emotions (made up of a deficit of appropriate regulation strategies, and a surplus of maladaptive regulation strategies; Carpenter & Trull, 2013; Linehan, 1993).

Individuals with *high sensitivity to emotion stimuli* have a limited capacity or threshold for emotions and experience a quick reaction to negative emotional cues (Linehan, 1993). Another aspect of emotion vulnerability is *emotional intensity*, which simply refers to an intense reaction to emotion-provoking situations or stimuli that disrupts cognition and the ability to self-regulate (Linehan, 1993). A third aspect of emotion vulnerability is *slow return to baseline*, which refers to long-lasting intense emotional reactions that focus the individual's attention to negative aspects of their environment that ultimately maintain their current negative mood (Linehan, 1993). Thus, individuals who face difficulty regulating their emotions, especially individuals with BPD, typically experience intense and labile affect. Often, difficulties regulating or controlling their emotions are based on self-deprecation of experiencing their emotions; thus, according to Linehan, affect regulation must first be paired with emotional self-regulation (Linehan, 1993).

Emotion regulation. DBT teaches four behavioral skills: mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation. Given this section's focus on emotional regulation, all of the specific DBT skills for regulating emotions are subsequently described in this subsection.

One skill used to regulate emotions is *Identifying and Labeling Affect* (Linehan, 2015).

This crucial step involves observing and describing:

(1) The event prompting the emotion; (2) the interpretations of the event that prompt the emotion; (3) the phenomenological experience, including physical sensation, of the emotion; (4) the expressive behaviors associated with the emotion; and (5) the aftereffects of the emotion on one's own functioning (Linehan, 1993, p. 149).

Another skill Linehan addresses for emotion regulation is *Identifying Obstacles to Changing Emotions* (Linehan, 2015). Because such obstacles are typically followed by consequences that are consistently being reinforced, it is important to learn to identify the functions and reinforcers for specific emotions. According to Linehan (1993), individuals are more susceptible to dysregulating emotions when they are under physical or environmental stress, which can lead them to react more to "emotional mind" than a more balanced "wise mind" (p. 63).

Reducing Vulnerability to Emotion Mind is an emotion regulation skill that focuses on limiting the likelihood of negative emotional reactivity when a person is under physical or environmental stress (Linehan, 2015). Engaging or creating self-care activities that aim to increase mastery and a sense of self-efficacy, such as engaging in physical exercise, eating balanced and nutritional meals, and receiving a sufficient amount of sleep, ultimately can enhance mood and provide a buffer for experiencing intense negative affect.

Another skill that Linehan identifies as being critical for emotion regulation is *Increasing Positive Emotional Events* (Linehan, 2015). It is recommended that individuals seek to increase

positive emotions by increasing the amount of positive emotional events in their lives, which ultimately provides them with control over their own emotional states. According to Linehan (1993), increasing positive emotional events ultimately means making life changes that will serve to increase the frequency of positive events.

Next, *Increasing Mindfulness to Current Emotion* (Linehan, 2015) involves attending to and experiencing emotions without judging, blocking, inhibiting, or distracting them (Linehan, 2015). The rationale for staying present with negative emotions is based on exposure, whereby painful emotions can be experienced without negative consequences, which will eventually prevent the generation of secondary negative emotions.

Lastly, *Taking Opposite Action* involves responding behaviorally in ways that are opposite of the specific emotion (Linehan, 2015). The emphasis on this skill is to not inhibit the negative emotion, but to learn to express a different, adaptive emotion (Linehan, 1993).

In conclusion, within the context of psychotherapy, Marsha Linehan's Biosocial Model is a widely used and understood model of emotion regulation. This model provides a base for the use of DBT as an effective modality to treat emotion dysregulation, specifically with individuals diagnosed with Borderline Personality Disorder. DBT has also been adapted for use with a variety of other populations, such as suicidal adolescents, and people with substance use issues and binge eating disorders (Koerner & Dimeff, 2000). While no specific assessment measures have been formulated from this particular modality, measures such as the DERS (Gratz & Roemer, 2004), which assesses for emotion regulation, are commonly utilized in clinical settings to gather information related to an individual's degree of emotion dysregulation. In comparison to other models previously noted, Linehan's model takes into consideration biological and

environmental factors, as well as cognitive, behavioral, and affective avoidance strategies, that contribute to an individual's maladaptive regulation strategies.

Acceptance and commitment therapy. Like DBT, Acceptance and Commitment Therapy (ACT) is a third-wave form of psychotherapy that targets emotional distress and inflexibility. ACT uses behavioral theory and relational frame theory to inform a model for interventions that assist people in regulating emotions as well as thoughts and behaviors (Harris, 2009). The treatment focus of ACT utilizes six core therapeutic processes, graphically presented as a hexaflex, that ultimately help to foster adaptive emotion regulation strategies (Harris, 2009). Overall, ACT was developed to teach individuals to increase psychological flexibility and valued living in order to take action that is consistent with their values, thereby enriching individuals lives (Harris, 2009). In a review of outcome research, Woidneck, Pratt, Gundy, Nelson, and Twohig (2012) concluded that preliminary data showed ACT to be effective in use with diverse populations. As ACT attempts to enhance psychological flexibility rather than emphasizing rationality, it may potentially provide a culturally sensitive treatment modality for working with diverse populations (Woidneck et al., 2012).

Regarding its conceptualization of emotional regulation and dysregulation, ACT takes the view that attempts to regulate emotions can be a significant cause of psychopathology (Hayes, Strosahl, & Wilson, 1999). According to the ACT model, the experience of unpleasant emotion is the result of distorted cognitive processes that eventually lead to behaviors that are problematic and used to avoid or reduce the unpleasant emotions (Blackledge & Hayes, 2001). Maladaptive behaviors may lead individuals to live their daily lives incongruent to their values, thereby perpetuating their experience of unpleasant emotions. Furthermore, cultural conventions affect how we evaluate emotions, as being either positive or negative (Blackledge & Hayes, 2001).

Experiential avoidance occurs when individuals avoid experiencing their private experiences (e.g., bodily sensations, emotions, thoughts, memories, behaviors), possibly leading to an increase in maladaptive behavior (e.g., substance abuse, high-risk sexual activities, avoiding intimacy and relationships) (Blackledge & Hayes, 2001). In addition, according to the ACT model, avoiding one's own inner experiences results in the exacerbation of the avoided and unwanted thoughts and feelings (Blackledge & Hayes, 2001).

The six core therapeutic process of ACT, Contacting the Present Moment, Defusion, Acceptance, Self-As-Context, Values, and Committed Action, help to facilitate psychological flexibility, openness to experience, and a greater quality of life (Harris, 2009). Contacting the Present Moment involves bringing attention to the present moment instead of tuning out to emotional experiences that may lead to experiencing distress (Harris, 2009). Defusion refers to the detachment from negative cognitions, and, rather, observe the nature of the thoughts without judgment (Harris, 2009). Acceptance, critical to emotion regulation, involves allowing a space to experience painful emotions without struggling or avoiding them (Harris, 2009). Self-as-Context is otherwise understood as “the observing self,” which notices and observes thoughts, images, emotions, etc. (Harris, 2009, p.11). ACT also seeks to help facilitate a clarification of the individual's Values, which ultimately serve as a guide or roadmap to how the individual behaves (Harris, 2009). Finally, Committed Action is the step taken to achieving an enriched and fulfilled life that is guided by the individual's values (Harris, 2009).

In summary, ACT asserts that the ability to notice and label emotions and thoughts allows individuals to experience and evaluate their internal struggles. By combating experiential avoidance, individuals are better able to move towards their values and goals.

Summary. DBT and ACT are third-wave, cognitive-behaviorally-based models that aim to provide individuals with emotion regulation skills. Both models hold that cognitions affect the types of emotions experienced, ultimately affecting how individuals manage or avoid these emotions through specific behaviors. DBT and ACT state that maladaptive cognitions lead to the experience of distressing emotions, and that attempts to regulate and/or avoid these emotions may result in psychopathology. These models propose specific skills that similarly address emotion regulation, including increasing emotional awareness through mindfulness. For example, DBT's *Increasing Mindfulness to Current Emotion*, which involves experiencing emotion without judgment, is similar to the ACT skills of Defusion and Self-as-Context, where the emphasis is placed on observing thoughts and emotions without self-judgment. Given these similarities, further research may be indicated to illustrate the effectiveness of the integration of both ACT and DBT in the regulation of emotion.

While both DBT and ACT hold similar premises and skills, differences between these models exist. DBT places a heavy emphasis on the experience of emotions and proposes specific skills to use in order to regulate distressing emotions while ACT places an increased focus on normal and maladaptive cognitions that serve to distort or exacerbate negative emotions (Harris, 2009). ACT also aims to increase psychological flexibility in order to live a fulfilled life guided by the individual's values. Similarly, a key goal in DBT is to create a life worth living. Given DBT's explicit focus on individual values, ACT may be more amenable than DBT to individuals of collectivistic cultures as psychological flexibility in line with an individual's cultural values is emphasized (Woidneck et al., 2012). Furthermore, as ACT takes into consideration various cultural processes, it is viewed as a non-stigmatizing universal treatment approach (Boone, Mundy, Morrissey, Stahl, & Genrich, 2015). However, current research reveals that DBT and

other mindfulness-based treatments can be adapted and enhanced for use with non-dominant and ethnic minority populations (Cheng & Merrick, 2017; Fuchs, Lee, Roemer, & Orsillo, 2013; McFarr et al., 2014). In any therapeutic approach, assessment with the individual is warranted to determine appropriate treatment interventions based on various cultural factors and demographics, including level of acculturation.

Assessment of Emotional Regulation and Dysregulation

Various clinical assessment tools exist to measure emotional responses and expressions as related to emotion regulation and dysregulation. In the emotion field, a variety of stimulus tools are used to elicit emotion, such as with pictures, film, sounds, words, and social interactions (Cacioppo & Gardner, 1999). Emotions and emotional reactions are subsequently studied. Tools used to measure the biological and cognitive aspects of emotion include Functional Magnetic Resonance Imaging (fMRI) and Positive Electron Topography (PET; Cacioppo & Gardner, 1999). These tools have also been used to study emotion regulation, such as Goldsmith, Pollack and Davidson (2008) who presented participants with a negative emotional stimulus (i.e., “negative picture”) and used fMRI to measure individual differences between emotion startle potentiation after the negative emotional stimulus was removed (p. 135).

Data on emotions can also be gathered through qualitative methods, such as interviews, field study, observational research, and experience sampling methods (ESM) or ecological momentary assessment (EMA). Observational coding systems have been used to study expressions of emotions and its components in adults (child, couples and family methods are outside the scope of this review), such as facial (e.g., Facial Affect Coding System; Ekman & Rosenberg, 1997), facial and emotional (e.g., Emotional Facial Action Coding System; Ekman & Friesen 1975); vocal (Douglas-Cowie, Cowie, & Schroeder, 2003; Juslin & Scherer, 2008), and

behavioral (Reisenzein, Junge, Studtmann, & Huber, 2014) or body movements (Dael, Mortillaro, & Scherer, 2012; de Lera, & Garreta-Domingo, 2007; Huis In't Veld, Van Boxtel, & de Gelder, 2014). Observational coding systems for use in psychotherapy by trained raters have been created that include attention to client emotion, such as The Change and Growth Experiences Scale (CHANGE; Hayes, Feldman, & Goldfried, 2007) and the Classification of Affective Meaning States (CAMS; Pascual-Leone & Greenberg, 2007). Electronic recording systems used by clients themselves during assessment, treatment and research also involve emotional ratings and feedback (I. Kramer et al., 2014; Walz, Nautra, & aan het Rot, 2014).

Because conducting individual assessments with Middle Eastern clients may be difficult, due to barriers including language, level of education, and reluctance to provide information out of fear of government intervention, especially post 9/11, Nassar-McMillan and Hakim-Larson (2003) proposed that conducting qualitative case and field study research methods (e.g., group interviews, observational methods) could be an effective way of gathering data from this population. Only two studies using such methods (group interviews specifically) were located during an extensive literature review of assessment with adult Middle Eastern clients, which are described below.

Nassar-McMilan and Hakim-Larson (2003) interviewed ten therapists of Middle-Eastern background who provided services to a large Arab American population in a community mental health agency. Information from the group interview yielded information on the clientele's "(a) background information on the population, (b) issues presented by clients representing the population, (c) barriers and recommended approaches to counseling individuals from the population, and (d) therapy and therapist dynamics" (Nassar-McMillan & Hakim-Larson, 2003, p. 152). The authors of the study discovered that PTSD, depression, and substance abuse

overwhelmingly afflicted the Iraqi post-war refugee subgroup of the study (Nassar-McMillan & Hakim-Larson, 2003). While the study was effective in gleaning information from therapists working with the Middle-Eastern population in one specific community in the United States, the authors recommended that more information be qualitatively gathered by conducting studies across various communities in the country.

Additionally, Hakim-Larson, Kamoo, and Voelker (1998) conducted 18 individual phone calls or in-person interviews with clinicians serving the Arab American population to gather data on the most prevalent concerns facing this community. Their study revealed that therapists working with this population frequently addressed “cultural difficulties; marital problems; school/education related issues; behavior problems or developmental disabilities; and mental disorders such as major depression, bipolar disorder, and schizophrenia” (Nassar-McMillan & Hakim-Larson, 2003, p. 152). Akin to the limitation described in the study conducted by Nassar-McMillan and Hakim-Larson (2003), the phone calls and in-person interviews were conducted with clinicians serving one particular community. Thus, a broader range and more in-depth analysis of concerns facing Middle-Eastern communities across the nation are needed in the literature.

Another frequently used assessment method in the field of emotion is self-report measures. Self-report assessment measures are valuable tools used to glean additional information from individuals who may be otherwise less forthcoming about their presenting problems, especially with mental health clinicians. This is consistent with information in the research literature concerning Middle Eastern Americans who may be hesitant to engage in self-disclosure (Orozco & Blando, 2010), due in part to fear of governmental repercussions following 9/11 (Awad, 2010). With this knowledge, Awad (2010) utilized several methods of data

collection, such as paper and Internet surveys, which were distributed via snowball sampling, as well as e-mail surveys sent to listservs. Thus, self-report measures can provide additional data concerning the emotional lives of the Middle Eastern population that may be otherwise difficult or impossible to obtain via interview or observation.

The following subsection reviews a non-exhaustive list of self-report assessment measures that were chosen upon careful review of individual items that tapped into relevant areas of emotional expression, emotion regulation, and emotion dysregulation. Based on the literature review conducted to date, only four of the following measures appear to be used with the Middle Eastern population. Thus, the measures described below were chosen for description based on the comprehensive nature by which they describe various measures of emotion, as well as for their potential utility for use with the Middle Eastern population.

Emotional expression measures. The self-report instruments used to measure emotional expression reviewed here are the *Emotional Expressivity Scale*, *Berkeley Expressivity Questionnaire*, and the *Toronto Alexithymia Scale-20*. A review of the literature did not yield any studies examining the aforementioned measures for use with the Middle Eastern population.

The *Emotional Expressivity Scale* assesses general emotional expressivity (EES; Kring, Smith, & Neale, 1994). According to Kring et al., (1994), the EES has high reliability, with an average Cronbach alpha of .91 and a four-week test re-test correlation of .90. Convergent and discriminant validities show that the EES is highly related to measures that assess affect intensity, self-monitoring, and Big-5 Personality factors of Neuroticism and Extraversion (Kring et al., 1994). Test norms were established with six samples of undergraduate university students or adult community residents; however, specific cultural demographics of the normative group were not provided. The 17-item, self-report questionnaire measures the extent to which

individuals display their emotions, both positively and negatively and in any general manner of expression (i.e., facially, vocally, or gesturally; Kring et al., 1994). Sample items include, “I am able to cry in front of other people” and “Even when I’m experiencing strong feelings, I don’t express them outwardly.”

The *Berkeley Expressivity Questionnaire* (BEQ; Gross & John, 1997) is a 16-item self-report instrument that measures the strength of emotional responses and the degree to which they are expressed. Additionally, the BEQ measures individual differences in emotional expression. Three factor-analytically derived subscales on the BEQ measure impulse strength (e.g., “I am sometimes unable to hide my feelings, even though I would like to”), negative expressivity (e.g., “People often do not know what I am feeling”), and positive expressivity, (e.g., “I am an emotionally expressive person;” Gross & John, 1997). Demonstrating convergent validity, the three subscales of expressivity were shown to be negatively correlated with Watson and Greer’s (1983) emotional control scale. In terms of discriminant validity, the negative expressivity subscale is highly correlated with the emotional control scale than the positive expressivity subscale (Gross & John, 1995). The normative sample of the BEQ consisted of undergraduate students from the University of California at Berkeley, with a mean age of 19.0 (SD=1.3). The cultural demographics of the sample include 7% African American, 33% Asian American, 34% Caucasian, 16% Hispanic, and 10% Other (Gross & John, 1995). The instrument’s 16 items were demonstrated to be positively intercorrelated to each other (mean inter-item $r = 0.27$), with a coefficient χ -reliability of the scale was 0.85 of the sample, and test-retest reliability was significant ($r = 0.86$) (Gross & John, 1995).

The *Toronto Alexithymia Scale-20* is a self-report measure, which includes 20 items that measure difficulty identifying feelings, difficulty describing feelings, and externally oriented

thinking (TAS-20; Bagby, Parker, & Taylor, 1994). Sample items include “I am often confused about what emotion I am feeling,” “It is difficult for me to reveal my innermost feelings, even to close friends,” and “Being in touch with emotions is essential.” The derivation sample consisted of 389 males and 576 females, all of whom were University students with a mean age of 21.8 years ($SD = 5.6$). The instrument is shown to have good test-retest reliability (0.77) and a high coefficient alpha of 0.81 demonstrates good internal reliability (Bagby et al., 1994).

Emotion regulation measures. The emotion regulation measures highlighted in this subsection are the *Trait Meta-Mood Scale*, the *Negative Mood Regulation Scale*, *Emotion Regulation Questionnaire*, and the *Cognitive Emotion Regulation Questionnaire*. The *Trait Meta-Mood Scale*, the *Emotion Regulation Questionnaire* and the *Cognitive Emotion Regulation Questionnaire* are two of the aforementioned emotion regulation questionnaires that have been translated for use with Middle Eastern populations.

The *Trait Meta-Mood Scale* (TMMS) assesses “individual differences in the ability to reflect upon and manage one’s emotions” (Salovey, Mayer, Goldman, Turvey, & Palfai, 1995, p. 126). The TMMS is a self-report measure where participants rate the degree to which they endorse statements regarding their emotions. Akin to the NMR, the TMMS measures emotional avoidance in its Repair subscale; however, the TMMS also assesses emotional awareness and understanding in its Attention subscale (e.g., “I try to think good thoughts no matter how badly I feel,” (Gratz & Roemer, 2004) “One should never be guided by emotions,” and “It’s important to block out some feelings in order to preserve your sanity” (Salovey et al., 1995). The Clarity scale includes items such as, “I can’t make sense out of my feelings,” and “I am usually very clear about my feelings” (Salovey et al., 1995). The TMMS demonstrated to have adequate convergent

and discriminate validity, and three subscales demonstrated strong internal consistency, ranging from 0.82 to 0.85 (Salovey, Stroud, Woolery, & Epel, 2002).

Moreover, the *Trait Meta-Mood Scale* was translated in Farsi for use with a sample of 306 undergraduate Iranian students (Bayani, 2009). The sample consisted of 123 males and 183 females, aged 18 to 51 ($M = 25.4$, $SD = 6.1$; Bayani, 2009). Reliability was measured using test-retest and internal consistency methodology, with test-retest reliability measuring .77 and internal consistency measuring .79 (Bayani, 2009).

The *Negative Mood Regulation Scale* (NMR), a 30-item self-report instrument of emotion regulation, specifically measures the beliefs that a “behavior or cognition will alleviate a negative state or induce a positive one” (Catanzaro & Mearns, 1990, p. 547). Furthermore, the NMR emphasizes how one attempts to avoid negative emotions rather than modulate his/her behaviors while confronted with negative emotions. The NMR assumes that all emotion regulation strategies are adaptive regardless of context, and strategies listed in this measure link emotional regulation with emotional avoidance (Gratz & Roemer, 2004). Sample items include, “When I’m upset, I believe that I won’t be able to put it out of my mind,” “When I’m upset, I believe that I can forget about what’s upsetting me pretty easily.” and “Trying to work the problem out in my head will only make it seem worse.” While the NMR does not assess important aspects of emotion regulation, including awareness, understanding, and acceptance of emotions, Gratz and Roemer (2004) conclude that it is an adequate measure that assesses a person’s access to emotion regulation *perceived* as effective. The normative sample consisted of 1,630 undergraduates; however, specific demographics were not provided. The NMR was demonstrated to have good internal consistency, discriminant validity, and good test-retest reliability ($r = .74$ for women; $r = .76$ for men; Catanzaro & Mearns, 1990).

The *Emotion Regulation Questionnaire* (ERQ; Gross & John, 2003) is a 10-item self-report instrument that assesses emotion regulation, utilizing two subscales measuring cognitive reappraisal and suppression. Each item utilizes a 7-point scale, beginning with 1 (*strongly disagree*) to 7 (*strongly agree*). The subscale that measures reappraisal includes sample items such as “I control my emotions by changing the way I think about the situation I’m in” and “When I want to feel less negative emotion (such as sadness or anger), I change what I’m thinking about”). The suppression subscale includes items such as, “I control my emotions by not expressing them” and “When I am feeling negative emotions, I make sure not to express them” (Gross & John, 2003). In terms of psychometric properties and ethnic differences, results from the original normative sample of the ERQ indicate that ethnic minority groups in the United States use suppression more frequently than European Americans (Gross & John, 2003). The normative sample consisted of undergraduate students consisting of European American, African American, Asian American, and Latino ethnic groups. Ethnicity effects were tested using one-factorial analyses of variance (ANOVAs), indicating that in both samples European Americans utilized suppression the least among the African American, Asian American, and Latino groups (Gross & John, 2003). The three minority groups did not differ from each other in the ANOVAs that compared the three minority groups and there were no differences among ethnicities for Reappraisal (Gross & John, 2003). Alpha reliabilities were .79 for Reappraisal and .73 for Suppression and test-retest reliability was .69 for both subscales after three months (Gross & John, 2003). Further, convergent and discriminant validity were demonstrated through conceptually related constructs, such as perceived emotion regulation success, inauthenticity, coping, and mood regulation (Gross & John, 2003).

More recently, the ERQ was independently translated in a study examining cross-cultural differences in emotion regulation across 1852 undergraduate students from three Arabic-speaking countries (Egypt ($n = 355$), Kingdom of Saudi Arabia (KSA; $n = 315$), Qatar ($n = 400$), and Kuwait ($n = 400$), and one English-speaking country (USA; $n = 382$; Megreya, Latzman, Al-Emadi, & Al-Attiyah, 2018). The study's sample mean age was 18.9 ± 1.9 years and 50.6% were female (Megreya et al., 2018). Across all four Arabic-speaking countries, the positive regulation strategies of *Acceptance*, *Positive Refocusing*, *Positive Reappraisal*, *Putting into Perspective* and *Refocus on Planning*, were positively associated with positive affect and negatively associated with negative affect (Megreya et al., 2018). However, the study found that Americans had lower scores on Suppression than participants from the Middle-Eastern/Arabic-speaking countries. Internal consistencies for the subscales were moderate to high (.75 to .89; Megreya et al., 2018).

The *Cognitive Emotion Regulation Questionnaire (CERQ)*, which has been translated into Arabic (CERQ-Ar) and Farsi, was developed to distinctively measure cognitive processes utilized to regulate emotions, specifically experiences of negative events (Garnefski & Kraaij, 2007). The CERQ differentiates nine cognitive processes an individual utilizes to measure thoughts following the experience of a negative life event: *Self-blame*, *Other-blame*, *Rumination or focus on thought*, *Catastrophizing*, *Putting into perspective*, *Positive refocusing*, *Positive reappraisal*, *Acceptance*, *Refocus on Planning* (Garnefski & Kraaij, 2007). In a general sample of adults ages 18 to 65 ($n = 611$) the CERQ was demonstrated to show good factorial validity and high reliabilities, including Cronbach's alpha between .75 and .87. Of note, strong relationships were found between emotional disorders (e.g., anxiety and depression) and with the cognitive emotion regulation strategies of self-blame, rumination, catastrophizing, and inverse positive reappraisal (Garnefski & Kraaij, 2007). The French version of the CERQ revealed

acceptable to good reliabilities, including Cronbach's alpha between .68 to .87 (Jermann, Van Der Linden, D'Acremont, & Zermatten, 2006).

Of particular interest to the present study, there have been two versions of this measure developed for Middle Eastern populations. Megreya, Latzman, Al-Attiyah, and Alrashidi (2016) noted that that because there had been no large scale study examining emotion regulation among Arabic-speaking individuals in the Middle East, there was a need to better understand cognitive emotion regulation processes to help improve assessment and treatment.

Thus, first, the *Cognitive Emotion Regulation Questionnaire Arabic Version* (CERQ-Ar) was developed to better understand cognitive processes underlying emotion regulation among Arabic-speaking individuals (Megreya et al., 2016). Psychometric properties for the CERQ-Ar among four Arabic-speaking countries (i.e., Egypt, Kingdom of Saudi Arabia, Kuwait, & Qatar) primarily among undergraduate university students ($n = 1470$) indicated moderate (0.66) to high reliability (0.84; Megreya et al., 2016).

Overall, the nine-factor model of the original CERQ was consistent across the four Arabic-speaking countries, highlighting that cognitive emotion regulation strategies appear to be universal. With that said, however, the preference to use one or more strategies varied across cultures and gender (Megreya et al., 2016). For example, females had higher scores on Rumination than males across all four countries, with a large effect size of 0.49, which the authors suggest could yield important information about how rumination is a significant cognitive emotional processing component among females across these four countries. While the authors suggested that 0.49 was a large effect size, this researcher noted that is generally considered to be a medium effect size (Cohen, 2013).

Second, the Persian (i.e., Farsi) translated version of the CERQ was studied in a university student population in Iran ($n = 503$) and revealed moderate (0.64) to high reliability (0.82), similar to the CERQ-Ar (Abdi, Taban, & Ghaemian, 2012). Gender differences among scores were also examined; for instance, men scored higher on *Acceptance* whereas women scored higher on *Putting into perspective* and *Catastrophizing*. Specific references to cultural differences in utilization of cognitive strategies to regulate emotions were not largely examined, although the authors noted that *Self-blame* “shows cultural property among Iranian students” and that further study was warranted (Abdi et al., 2012, p. 6).

Emotion dysregulation measures. The measures of emotion dysregulation highlighted in this subsection include the *Difficulties in Emotion Regulation Scale*, and the *Acceptance and Action Questionnaire*. The *Difficulties in Emotion Regulation Scale* has been translated in Farsi and adapted for use in an Iranian clinical sample (described below).

In an effort to narrow the gap in the literature and clinical utility of assessment of emotion dysregulation, the *Difficulties in Emotion Regulation Scale* (DERS; Gratz & Roemer, 2004) was developed to provide a more comprehensive clinical assessment of emotion dysregulation. According to Gratz and Roemer (2004):

Items on the DERS capture difficulties within the following dimensions of emotion regulation: (a) awareness and understanding of emotions; (b) acceptance of emotions; (c) the ability to engage in goal-directed behavior, and refrain from impulsive behavior, when experiencing negative emotions; and (d) access to emotion regulation strategies perceived as effective (p. 43).

The DERS also includes a final dimension to measure flexibility in the use of appropriate modulation of emotional responses (Gratz & Roemer, 2004). Sample items include, “When I’m upset, I acknowledge my emotions,” “When I’m upset I believe that my feelings are valid and important,” and “I am confused about how I feel.” The normative sample consisted of 357

participants, with ages ranging from 18-55 (mean age = 23.10; $SD = 5.67$). In terms of specific ethnicities, 65% identified as White, 17% as Asian, 8% as Black/African American, 4% as Hispanic/Latino, and 6% reported as Other (Gratz & Roemer, 2004). The DERS was demonstrated to show high internal consistency ($\alpha = .93$), with item correlations ranging from $r = .16$ to $r = .69$ (Gratz & Roemer, 2004). The subscales showed adequate internal consistency (Cronbach's $\alpha > .80$ per subscale; Gratz & Roemer, 2004). Test-retest reliability was demonstrated to be good ($.88, p < .01$) and was measured over a period of four to eight weeks.

The *Difficulties in Emotion Regulation Scale*, 5th and 6th (DERS-5-revised) and (DERS-6), editions have also been translated in Farsi (Mazaheri, 2015). These versions have been described as culturally adapted for use with the Iranian population; however, the details of such work were not able to be located. Moreover, construct validity and reliability of both editions were studied to determine construct validity and reliability, and were adapted for use in a clinical sample of 181 patients (33 males and 148 females) ages 18-66 (Mean age = 36.34) presenting at a digestive psychosomatic clinic with functional gastrointestinal disorders in Iran (Mazaheri, 2015). Results from the study revealed good internal consistency between the two forms ($\alpha = 0.90$; Mazaheri, 2015).

The *Acceptance and Action Questionnaire - II* (AAQ-II) aims to measure experiential avoidance (i.e., the avoidance of inner experiences such as unwanted emotions and thoughts; (Bond et al., 2011). The AAQ-II is a ten-item, self-report measure that assesses experiential avoidance and control, negative evaluations of internal experience, presence or lack of psychological acceptance, and the extent to which an individual behaves regardless of distress or how the distress affects behavioral avoidance (Bond et al., 2011). Examples include, "I'm afraid of my feelings," "Emotions cause problems in my life," and "It's OK if I remember something

unpleasant.” The normative sample consisted of 2,816 mostly Caucasian participants across six samples, and appeared to demonstrate good reliability and validity (Bond et al., 2011). The mean alpha coefficient is .84, and test-retest reliability was .81 at 3 months and .79 at 12 months (Bond et al., 2011). The authors indicate that the AAQ-II demonstrates good discriminant and convergent validity (Bond et al., 2011).

Summary. In sum, assessment of emotion, emotion regulation, and emotion dysregulation can be conducted utilizing physiological, qualitative, and quantitative methodologies. As previously noted, gathering data from the Middle Eastern population qualitatively may be faced with challenges, such as reluctance to self-disclose, as well as miscategorization of the Middle Eastern identity. Of the measures described, only several were translated for use among population samples in Iran and in four Arabic-speaking countries: Egypt, Kingdom of Saudi Arabia, Kuwait, and Qatar. However, information is lacking regarding what, if any, other cultural adaptations were made to these measures. Also, no measures have been specifically developed from within these populations. Thus, among Middle Eastern Americans, quantitative methods using self-report measures as well as observational methods and telephone interviews, can facilitate the gathering of data on how this population experiences emotion, emotion regulation, or emotion dysregulation in a method that protects the individual’s privacy.

Current Status of Theory and Research on Middle Eastern Clients in Psychotherapy

Much of the information represented in the literature regarding Middle Eastern individuals in psychotherapy is based on recommendations from authors who primarily treat individuals of these ethnicities. Although such authors’ opinions on best practices when working with these individuals are helpful, there is a need for further research on Middle Eastern

individuals in psychotherapy that provides information as to how emotion regulation and dysregulation are observed in the treatment setting as a means to inform clinicians how to identify and facilitate culturally sensitive treatment of emotion dysregulation within this specific population.

To inform such work, this section begins by exploring broadly Middle Eastern cultural identities, including the various ethnic, national, and religious subcultures, immigration and acculturation statuses, and cultural values and beliefs. Next, this section covers communication and affective expression among individuals of Middle Eastern descent. Lastly, this section reviews the current status of research among the more specific group of individuals of Middle Eastern descent in psychotherapy.

Middle Eastern cultural identities. Middle Eastern individuals are comprised of diverse ethnic, national, and religious backgrounds. Often the terms Middle Eastern, Arab, and Muslim are confused and used interchangeably; however, each term references a different ethnic and religious group that is representative of this geographic region (Hilliard et al., 2012). While there is no concise definition for what encompasses the Middle East, for the purposes of this study, the Middle East as a geographical location is defined as encompassing Egypt, the Arab countries of Asia (Bahrain, Iraq, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syria, United Arab Emirates, Yemen), Israel, Afghanistan, Turkey, and Iran (Sayyedi et al., 2011). Historical migration patterns throughout the region resulted in distinct cultural heritages throughout the region, which are reflected by their spoken languages: Arabic, Armenian, Persian, Turkish, and Hebrew (Sayyedi et al., 2011). In addition, due to wars, migration patterns, and sociopolitical changes and unrest, the region also encompasses Kurds, Armenians, and Druze (Sayyedi et al., 2011). Thus, the Middle East is not defined by one ethnic, religious, or national

background; rather, it is a combination of the aforementioned variables in addition to geopolitical factors.

According to the 2009 United States census, slightly under three million respondents indicated identification with Middle Eastern ethnicity. This estimate includes about 1,680,018 million Arab Americans, 484,840 Armenian Americans, 469,569 Iranian Americans, 187,399 Turkish Americans, and 139,177 Israeli Americans (U.S. Census Bureau, 2009).

Religious identities. The majority of individuals from the Middle East identify as Muslim, belonging to Sunni or Shiite factions. Also, many Middle Eastern individuals identify as Christian. This latter group in particular represents a large portion of immigrants currently living in the United States. Other religious minority groups present in the region include Jews, Druze, Alawites, Zoroastrians, Baha'is, Zaidis, and Yazidis (Abi-Hashem, 2010; Sayyedi et al., 2011).

Immigration history to the United States and acculturation. As previously mentioned, Middle Eastern individuals typically have immigrated to the United States in distinct waves. The first wave, occurring between 1890 and 1940, represented Syrian and Lebanese Christians in search of economic opportunities, as well as Armenian refugees escaping the genocide committed by the Turks (Abudabbeh, 2005; Dagirmanjian, 2005). The second wave of immigration occurred between 1940-1948. This second wave of immigration included Palestinian immigrants who were displaced from their homes during the establishment of the State of Israel in 1948, as well as Iranians, Arabs, and Armenians seeking higher education (Abudabbeh, 2005, Dagirmanjian, 2005, Jalali, 2005). The third wave of immigration occurred after the Arab-Israeli war in 1967 and also included different groups throughout the region: “the 1975-1990 Lebanese civil war, the 1979 Iranian revolution, the 1988 earthquake in Soviet Armenia, the 1990 conflict between Soviet Armenia and Soviet Azerbaijan, and the 1991 Gulf

War” (Sayyedi et al., 2011, p. 224). Presently, the United States is also experiencing a wave of immigration as a result of political unrest, genocide, and wars throughout the Middle East, specifically from Syria and Iraq.

Given the historical timeline of the waves of immigration, different generations of Middle Eastern Americans encompass different levels of acculturation. According to Berry, (1992), levels of acculturation manifest in two ways: immersion in or adoption of the dominant society and retention or immersion in the ethnic society. These levels result in assimilation to the dominant society, integration into both dominant and ethnic society, separation from dominant society, and marginalization of either society (Awad, 2010; Berry, 1992). This is an important distinction for mental health clinicians to consider when treating individuals of Middle Eastern background, as the individual’s beliefs and attitudes towards dominant and ethnic societies may or may not be foci of treatment. Falicov (2007) suggests that clinicians gain awareness and understanding of the relational, community, and cultural/sociopolitical stressors that new immigrants face. Such relational issues that may occur include changes in family dynamics, as tradition and modernity may become intertwined (Falicov, 2007).

Since September 11, 2001 (9/11), Muslim and Arab Americans have experienced increased discrimination and prejudice, and often violence (Ibish, 2003; Moradi & Hasan, 2004; Padela & Heisler, 2010). Further, policies developed in response to 9/11 by the United States include targeting Middle Eastern communities and religious institutions, as well as racial profiling (Ibish, 2003; Padela & Heisler, 2010; Zogby, 2001). The United States’ invasion of Iraq and Afghanistan in response to 9/11 may have created additional psychological distress among Middle Eastern Americans, many of whom were victims of discrimination, prejudice, and acts of violence. In a community-based sample of Arab American adults of the greater Detroit area,

Padela and Heisler (2010) found that the events following 9/11 revealed high levels of psychological distress, lower levels of happiness, and increased health problems among individuals who have experienced personal or familial discrimination and/or abuse.

Cultural values and beliefs. Despite group variances, the Middle East is a “cultural area” that shares values, concepts, and traditions (Gregg, 2005; Rassam; 1995; Sayyedi et al., 2011). One such shared and unifying feature is the importance of family (Al-Krenawi & Graham, 2000; Nassar-McMillan & Hakim-Larson, 2003). The collectivist culture shared by Middle Easterners places a heavy emphasis on the family unit, and eschews autonomy and individual independence typically valued in Western cultures, such as the United States (Haboush, 2007). Important decisions are typically made as a family unit, with the goal of preserving the family’s honor, cohesion, and stability (Haboush, 2007). Instead of developing individual coping strategies or utilizing external sources of support, children are encouraged to turn to the family unit for solutions to their problems (Al Krenawi & Graham, 2000).

The family unit is typically patriarchal in nature, where the father is considered to be the head of the household by which most private matters and health-related decisions are made (Hilliard et al., 2012). According to Jalali (2005), the cultural power hierarchy among Iranian American families, where the father is the head of the family unit and is typically to be first addressed, should always remain acknowledged by mental health clinicians when treating the family. However, it is also important to note that women play a powerful figure within the family unit, often viewed as the typical role in maintaining family cohesion (Haboush, 2005).

Across Middle Eastern groups, expectations for behaviors exist in various domains, and such behaviors are typically expected to be withheld by the family unit as a way to maintain honor. Typically, this code of honor resembles a set of guidelines that guide behavior between

the sexes, among elders, strangers, guests, and how to maintain honor and advancement of the family system (Abudabbeh, 2005; Gregg, 2005; Sayyedi et al., 2011). Maintaining privacy within the family unit is of significance, which reflects the importance of maintaining honor and upholding the name of the family. Deviations from these behaviors and expectations are viewed upon as shaming the family unit. Issues of privacy may signify implications for mental health clinicians (Abudabbeh, 2005), as clients of Middle-Eastern descent may be hesitant to fully disclose information to their treating clinicians, which may ultimately impact the ability to accurately diagnose and provide treatment.

Communication and Emotional Expression in Middle Eastern Culture

Affective expression. Differences in affective expression exist for individuals of Middle Eastern descent. Preservation of family honor inhibits affective expression in public, and introspection and expression of feelings is discouraged due to cultural values placed on the family unit (Haboush, 2005). According to Dwairy and Van Sickle (1996), exploration and awareness of an individual's feelings may lead to conflict within the family, as individual emotional insight is inconsistent with the importance of the family unit. While emotional expression is discouraged, male expressions of anger and aggressiveness are tolerated, accepted, and somewhat valued (Haboush, 2005).

Typical communication style among Middle Eastern individuals also involves expressions of affection, typically of endearment towards the other (Haboush, 2005). Direct expression of emotions and introspective feelings, however, are discouraged in public, including therapy sessions (Haboush, 2005). Additionally, Middle Eastern culture strongly values hospitality and agreeableness (Haboush, 2005). Communication may be indirect and idioms of

distress may be expressed metaphorically. The client may describe depression as “a dark life,” or fear as “my heart fell down” (Al-Krenawi & Graham, 2000, p. 14).

Concealment of emotion. The expression of conflict or negative feelings is not well accepted in Middle Eastern culture. Depressed mood may be viewed as “anxious self-absorption,” and may be negatively viewed by family and broader community as having a “narcissistic preoccupation” (Al-Krenawi & Graham, 2000, p. 16). Families of Arab descent typically adhere to “mosayara,” a basic coping skills that emphasizes getting along with others’ attitudes, wishes, and expectations by concealing one’s own feelings, thoughts, and attitudes (Dwairy, 2009, p. 202). When faced with stressors, individuals in these communities seek out family members for guidance, typically the elders.

Given the centrality of family among Iranian American families, inhibition of emotional disclosure is expected among individuals within the family unit (Jalali, 2005). While men in Middle Eastern cultures are encouraged to outwardly convey feelings of anger, women are discouraged from expressing their emotions due to cultural emphasis and values on the family unit, specifically pertaining to shame and honor (Haboush, 2005). Particularly among Iranian families, shame is utilized as a tool to shape obedience to the family (Frank, Plunkett, & Otten, 2010). Due to the decreased opportunity to convey emotional expression, women may present to treatment with internalizing disorders, specifically anxiety and depression, with somatic features (Abdi et al., 2012; Haboush, 2005).

Somatization of affective disorders. Due to the shame and stigma surrounding mental health disorders, as well as the general discouragement of the outward expression of emotions, there is a tendency for individuals of Middle Eastern descent to convey their distress through somatization (Al-Krenawi & Graham, 2000; Dwairy & Van Sickle, 1996; Erickson & Al-

Timimi, 2001; Sayed, 2003). Middle Eastern individuals typically seek treatment from physicians to address their physical complaints rather than refer themselves to mental health clinicians (Nassar-McMillan & Hakim-Larson, 2003).

Due to the cultural stigma associated with mental health and seeking treatment for psychological disorders, Middle Eastern individuals may not readily have the language to express emotions, or even mental health concerns, as separate from physical ailments (Erickson & Al-Timimi, 2001). Thus, physical complaints may serve as a “language” used to express their feelings (Haboush, 2005). Jalali (2005) notes that distress is frequently expressed through somatization, with specific symptoms of anxiety related to the heart: “aching, pounding, fluttering, rapid beating, pain, or discomfort” (p. 461). Depression and anxiety may be expressed as having “weak nerves, tired nerves, shaking hands, lack of sensation, and numbness” (Jalali, 2005, p. 461). Anxiety or depression may be described or concealed as having an aching body, or frequently expressed as having gastrointestinal issues (Erickson & Al-Timimi, 2001). In sum, discussion of physical symptoms carries less stigmatic weight than endorsing issues related to mental health.

Current Status of Research on Middle Eastern Clients in Psychotherapy

Middle Eastern individuals in psychotherapy are one of the most underrepresented groups in the research literature, with little published practice research on this population (Al-Krenawi & Graham, 2000). A review conducted by Boghosian (2011) of the literature on Middle Eastern Americans in psychotherapy produced nineteen articles written by clinicians treating individuals of Middle Eastern descent that highlighted various treatment recommendations for working with this population, inclusive of Arabs, Iranians, Muslims, and Armenians (viz., Abudabbeh, 2005; Abudabbeh & Aseel, 1999; Azary, 2006; Bushra, Khadivi, & Frewat-Nikowitz, 2007; Carolan,

Bagherinia, Juhari, Himelright, & Mouton-Sanders, 2000; Dagirmanjian, 2005; Dwairy, 1998; Erickson & Al-Timimi, 2001; Hall & Livingston, 2006; Jackson, 1997; Jalali, 2005; Kaeni, 2006; Kelly, Aridi, & Bakhtiar, 1996; Khalid, 2006; Nassar-McMillan & Hakim-Larson, 2003; Rehman & Dziegielewski, 2003; Sayed, 2003; Tahmassian, 2003; Vartan, 1997). According to Boghosian (2011), of these articles, 84% recommended that the clinician obtain an understanding of the individual's specific culture and 63% recommended assessing level of acculturation. As part of understanding the client's culture, Boghosian's (2011) review highlights that approximately 33%-50% of the authors reviewed suggested:

The therapist understand the religion of the client, experienced racism should be explored, somatization should be viewed as a culturally proscribed behavior rather than as pathology, psychotherapists should engage in examination of their own biases and stereotypes, and encourage therapist recognition of the diversity within the population (pp. 23-24).

Other recommendations from Boghosian's (2011) review are included in the discussion below. Following a review of the literature, this author found no other studies that contradicted Boghosian's review.

Although Middle Eastern individuals are a heterogeneous group, comprised of different religious, ethnic, and tribal cultures, these societies share similar contexts and attributes that have implications for culturally sensitive psychotherapy approaches. When identifying and disseminating culturally sensitive approaches to Middle Eastern individuals, incorporating the family unit is part and parcel of treatment. Much of the literature on counseling considerations with Middle Eastern clients highlights the value of the family unit, with a de-emphasis on individual identity given the stigma associated with the individual seeking mental health needs (Erikson & Al-Timimi, 2001). In Boghosian's review (2011), fewer than 50% of the articles surveyed discuss the importance of the family unit as being incorporated into treatment. Thus,

systems approaches that incorporate the family unit into treatment are advised (Erikson & Al-Timimi, 2001; Martin, 2014; Nobles & Sciarra, 2000).

Despite the importance of including the family unit in counseling, many Middle Eastern families resist treatment for emotional concerns and are generally skeptical of mental health clinicians due to the pervasiveness of stigma and negative attitude towards mental illness across these societies. Furthermore, undertaking counseling may be considered a sign of personal weakness and disloyalty to the family unit (Al-Issa, 2000). If they do present to treatment, many Middle Eastern clients are unwilling to admit to psychological distress due to such perceived shame or weakness (Nassar-McMillan & Hakim-Larson, 2003).

Furthermore, Middle Eastern culture strongly values hospitality and agreeableness, which may hinder treatment as the individual client could inhibit his or her emotional expression with the therapist (Abdulla & Brown, 2011; Haboush, 2005). Thus, clinicians may expect to encounter different styles of communication with this population, either a high level of affective expression (e.g., expressions of anger) or constricted affect (Haboush, 2005).

However, some studies suggest that Muslim Americans may be open to receiving psychotherapy (Carolan et al., 2000). Another study showed that while Muslim Americans may be open to receiving psychotherapy, it is important that the therapist be knowledgeable of Islamic beliefs and practices (Kelly et al., 1996). While not all Muslims in the United States are of Middle Eastern descent, these studies highlight the necessity for clinicians to remain culturally sensitive and respectful.

Previous studies regarding Arab Americans undergoing mental health treatment consist mainly of interviews and small-sample surveys, which may limit generalizability of findings (Amer & Hovey, 2007). These studies mainly consisted of an exploration of socio-demographic

and environmental factors impacting acculturation, which include “sex, religious affiliation, length of time in the USA, and stressors such as discrimination” (Amer & Hovey, 2007, p. 3). Despite the limited generalizability of the findings, these studies nonetheless produce data for further research, such as “systematic hypothesis-testing research” which can potentially provide more accurate information and generalizable findings to this population (Amer & Hovey, 2007, p. 344).

Common Presenting Problems and Specific Treatment Recommendations

According to Abudabbeh (2005), when Middle Eastern families do present to counseling, several themes may be prevalent. The mental health clinician should be aware of generational conflicts between parents and first generation children, who may be experiencing distress related to following traditional customs while simultaneously adopting the norms and values of the United States. For example, Jalali (2005) indicated that young Iranian Americans experience conflict between their desire to be independent from their family and their strong sense of kinship. Current literature suggests that Iranian families attempting to integrate into American culture face conflict between holding on to their old culture and acculturating into American society (Jalali, 2005). Biculturation research on Iranian Americans suggests that significant conflict and anxiety may arise within members of the family as they attempt to integrate both cultures (Jalali & Boyce, 1980).

Also, issues related to gender may arise as women are exposed to a more diverse and eclectic lifestyle. Further, family therapists may encounter families presenting to treatment to address conflicts between parents and their children regarding marriage, relationship partners, and expectations for child rearing, which may be especially compounded when these arise in the cross-cultural context. Importantly, when receiving mental health services, the individual may

expect the mental health practitioner to offer direct expert advice akin to a physician (Erickson & Al Timimi, 2001).

Similar themes as well as specific disorders appeared in a study by Hakim-Larson et al., (1998). The researchers found the following common presenting problems faced by this community as reported by clinicians through phone calls or in-person interviews, which included: “cultural difficulties; marital problems; school/education related issues; behavior problems or developmental disabilities; and mental disorders such as major depression, bipolar disorder, and schizophrenia” (Nassar-McMillan & Hakim-Larson, 2003, p. 152).

Nassar-McMillan and Hakim-Larson (2003) conducted a group interview with ten therapists serving the Middle-Eastern community and gathered the following information: “(a) background information on the population, (b) issues presented by clients representing the population, (c) barriers and recommended approaches to counseling individuals from the population, and (d) therapy and therapist dynamics” (p. 152). Issues presented by clients in the population studied include cultural difficulties, marital problems, school/education related issues, behavior problems or developmental disabilities, and mental disorders such as major depression, bipolar disorder, and schizophrenia (Nassar-McMillan & Hakim-Larson, 2003).

Of important note, many Middle Eastern Americans currently living in the United States have been exposed to trauma, war, and migration, which may indicate a likelihood of PTSD symptoms (Salem & Flaskerud, 2011). In order to provide culturally sensitive interventions, it is imperative to identify the prevalence and incidence of PTSD among Arab Americans living in the United States, with the inclusion of second and third generation individuals due to intergenerational trauma. When working with Middle Eastern individuals presenting with PTSD, Hilliard et al. (2012) suggest reframing the client’s history of survival and their ability to cope

with difficult situations as a strength, which can be a modulating factor for their distress.

Unfortunately, specific treatment approaches to target mental health disorders, including affective and anxiety disorders of interest to the proposed study, among Middle Eastern psychotherapy clients are lacking. Instead, what follows from the literature is based on the limited data sources of clinician recommendation and case studies.

The limited research on Middle Eastern individuals in psychotherapy that exists suggests that American or Western approaches to treatment should be carefully examined as it may be, or contain aspects that can be, culturally incongruent or insensitive. Traditional counseling techniques that emphasize emotional disclosure may lead to attrition (Dwairy & Van Sickle, 1996; Sayed, 2003). For example, in a case discussed by Ibrahim (2006), an Arab American female client nearly terminated treatment due to her clinician emphasizing assertiveness and teaching her how to outwardly express her anger; this approach was consistent with the cultural notion that females should not outwardly express feelings of anger (Kakoti, 2012).

The cultural emphasis placed on receiving advice from the family unit or the elders, highlights the hierarchical and authoritative structure to which many individuals of Middle Eastern descent adhere. Traditional Middle Eastern cultures turn to persons of authority whom they view as experts, such as physicians, for direct advice and explanations of their ailments (Erickson & Al-Timimi, 2001). Thus, these individuals may expect that the mental health clinician offer direct advice, which, while consistent within the medical field, may be inconsistent with psychotherapeutic practice.

Various recommendations have been made about the advantages and disadvantages of certain psychotherapy approaches. Boghosian (2011) highlighted that approximately 33%-50% of the authors reviewed suggested “a more directive form of psychotherapy be used, and

psychoeducation about counseling process should be included at the beginning of psychotherapy” (pp. 23-24). In accordance with that view, Abudabbeh and Hays (2006) suggested utilizing Cognitive Behavioral Therapy with the Arab American population, emphasizing that clinicians should direct these clients to focus on problems they face in present moment, providing psychoeducation regarding their stressors and their mental health, and cognitive restructuring to challenge the utility of the beliefs that maintain their symptoms. Advantages include emphasis on structure, psychoeducation, emphasis placed on shoring up support systems (e.g., family), problem-solving techniques, and attention paid to the present (Abudabbeh & Hays, 2006). They suggested that it is imperative for clinicians to respect clients’ needs and their own assessment of their stressors, while maintaining flexibility in the treatment setting, such as incorporating the family into treatment (Abudabbeh & Hays, 2006). Potential disadvantages of CBT include attention paid to autonomy, behavioral change, and rationality (Hays, 1995). Further, cognitive restructuring may be viewed as offensive and oppositional to cultural views (Abudabbeh & Hays, 2006).

When working with Iranian adolescents and families, Sayyedi (2009) proposed using her integrative approach combining Interpersonal Psychotherapy (IP), CBT, psychodynamic psychotherapy, pharmacotherapy, and psychoeducation, and concluded that this approach is based on her experiences as an Iranian-American, immigrant, mother, and psychologist working with this population. Abudabbeh and Hays (2006) would caution that, due to the cultural emphasis on the group or family system, insight-oriented individual therapy could yield anxious feelings for the Middle Eastern client (Abudabbeh & Hays, 2006).

Common to all recommended therapeutic approaches is flexibility and tailoring one’s approach to the client and his or her cultural identities. For example, Sayyedi (2009) suggests

when working with the Iranian client, the clinician should attempt to understand the client's experiences and avoid being influenced by ethnic stereotypes.

Conclusion. Therefore, while there are common characteristics that embody the Middle Eastern culture, it is imperative that the mental health practitioner asks about the client's acculturation status as a crucial part of tailoring treatment. Clinicians should challenge their assumptions when working with these clients. Further, despite common cultural themes, continuous evaluation of individual and family values and norms should be considered (Hilliard et al., 2012). Finally, research is needed that explores common themes and patterns of how emotion is expressed, regulated and/or inhibited within this population, as a means to inform clinicians how to address the facilitation of emotional expression and regulation that is culturally sensitive and appropriate.

Summary of Literature Review

Middle Eastern individuals represent diverse ethnic, national, and religious backgrounds. Within the United States, immigration from the Middle East occurred over time and in distinct waves. Different generations of Middle Eastern Americans encompass different levels of acculturation. General characteristics of Middle Eastern Americans include emphasis and value on the family unit, code of honor and maintenance of privacy within the family, inhibition and concealment of emotional/affective expression, and somatization of affective disorders.

Although literature on emotion and emotion regulation is widely established, there is a lack of empirical data regarding emotions and emotion regulation in the Middle Eastern population. Models of emotion, including appraisal and reappraisal mechanisms, and social construction models, appear to be well-represented constructs within the study of emotion that emphasize cultural factors in the understanding of emotions. As such, these models are pertinent

to the focus of study on emotion regulation as seen in Middle Eastern psychotherapy clients. Further, the Extended Process Model of Emotion Regulation, ACT, DBT, and the Instrumental Approach are widely researched models of emotion regulation that were reviewed by the researcher as these models incorporate cultural factors in the understanding of emotion regulation.

The assessment of emotion, emotion regulation, and emotion dysregulation can be conducted utilizing physiological, qualitative, and quantitative methodologies. Gathering data from the Middle Eastern population qualitatively may be faced with challenges, such as reluctance to self-disclose, as well as miscategorization of the Middle Eastern identity. Thus, the utilization of culturally adapted self-report measures as well as observational methods and telephone interviews, can facilitate the gathering of data on how this population experiences emotion, emotion regulation, or emotion dysregulation in a way that honors individual privacy.

Moreover, little research has been conducted with this population in the context of psychotherapy. Many Middle Eastern families resist treatment for emotional concerns and are generally skeptical of mental health clinicians due to the stigma towards mental illness across these societies. While there are common characteristics that embody the Middle Eastern culture, it is imperative that the mental health practitioner considers important variables when working with this population, such as assessment of acculturation, family values and norms, and to challenge therapist assumptions. Research focused specific culturally adapted treatment interventions and practices as well as about how Middle Eastern Americans express and regulate emotions in the psychotherapy setting is limited. Thus, research is needed that explores common themes and patterns of how emotion is expressed and/or regulated with population, in order to inform culturally sensitive treatment.

Chapter 3: Methodology and Procedures

Research Approach and Design

A qualitative analysis approach enables researchers to obtain a holistic understanding of clinical phenomena (Mertens, 2015). Data collected from the proposed study was collected from an observational perspective, which allows for the researcher to identify and describe the manner in which these observations occur in a naturalistic setting (Mertens, 2015).

As this study aimed to explore patterns and themes related to verbal expressions of emotional regulation that emerged in sessions with clients of Middle Eastern descent, an inductive coding approach was utilized. Rather than utilizing a deductive approach that is informed by existing theory, the inductive approach attempts to explore themes and categories that emerge from the observance of data (Hsieh & Shannon, 2005). By undertaking the inductive approach, the researcher withholds the imposition of preexisting knowledge in order to observe and learn new information that may provide additional useful data to existing literature (Schilling, 2006), in this case regarding emotion regulation among Middle Eastern American individuals in psychotherapy.

In particular, a conventional content analysis approach was utilized to observe themes that emerge from the gathered data in order to further classify the observable phenomena (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005; Weber, 1990). The content analysis approach is significantly useful when current research may be scarce or segmented (Elo & Kyngäs, 2008), as seen in the current state of research regarding emotion regulation among Middle Eastern Americans. The study's coding manual contains further details about background information pertaining to emotion, emotion regulation, and emotion dysregulation when analyzing the data (Appendix G).

Subjects/Participants and Consent/Human Subjects Procedures

Participant cases. Three psychotherapy cases were chosen from a Southern California university's community counseling center's archival research database. Initially, the researcher sought to utilize four cases; however, due to many charts containing damaged DVD recordings, only a total of three cases were available for this study. All data contained in the database have been de-identified and redacted to ensure client and therapist confidentiality. Approval from the university's Institutional Review Board (IRB) and the directors of the research database was obtained prior to the gathering of materials and data.

The qualitative process involved obtaining a rich description of the participants of the study. This was accomplished using materials from the research file that contained demographic and other relevant information about the course of treatment of the research participants. This information was obtained from the Client Information Form (Adult), and the Telephone Intake Interview. Because the Client Information Form (Adult) and the Telephone Intake Interview Form are clinic-created measures, there is no data regarding their reliability or validity.

Inclusion criteria for client-participants included being identified as Middle Eastern American (self-identified in the Client Information Adult Form), English speakers, and at least 18 years of age upon the initial intake. Translated sessions were excluded from this study for the purposes of maintaining consistency during transcription and coding. Written consent for videotaped and written materials was required from both participants (Appendix A) and therapists (Appendix B), and at least one working DVD needed to be available in the research files for each participant.

Exclusion criteria include individuals presenting to treatment in any of the clinics for family, couples, child or adolescent therapy. In order to protect the confidentiality and privacy of

participants, as well as to prevent personal biases from forming, the researchers were not allowed to code data of therapists or clients whom the researchers personally knew.

Table 1 provides a brief overview of the three client-participants chosen for the study. The subsequent paragraphs provide further detail regarding the clients' background information, presenting concerns, diagnoses, and therapy outcomes. Table 2 presents a reference of the client-participants with the session numbers selected for transcription and coding.

Table 1

Client-Participant (CP) Demographic Information

CP	Age	Gender	Ethnicity	Religion	Diagnoses at Intake	Diagnoses at Termination
1	25	Male	Iranian	Muslim & Catholic	Axis I: Partner Relational Problem Axis II: V71.09 No Diagnosis Axis III: none (per client report) Axis IV: stressful career, difficulties with mother Axis V: 76 (current)	N/A ¹
2	32	Female	Iranian & Romanian	Jewish	Axis I: 311 Depressive Disorder Not Otherwise Specified V61.20 Parent-Child Relational Problem V61.8 Sibling Relational Problem Axis II: 799.9 Diagnosis Deferred Axis III: None (per client report) Axis IV: Occupational Problems (viz., conflict with co-workers) Axis V: GAF = 70 (current)	Axis I: 311 Depressive Disorder Not Otherwise Specified V61.20 Parent-Child Relational Problem V61.8 Sibling Relational Problem Axis II: 799.9 Diagnosis Deferred Axis III: None (per client report) Axis IV: Occupational Problems (viz., conflict with co-workers) Axis V: GAF = 77 (current)
3	36	Male	Iranian & Israeli	Jewish	300.4 (F34.1) Persistent Depressive Disorder with Anxious Distress 300.23 (F40.10) Social Anxiety Disorder (Social Phobia) 301.82 (F60.6) Avoidant Personality Disorder (Provisional) 315.35 (F80.81) Childhood-Onset Fluency Disorder (Stuttering)	300.23 (F40.10) Social Anxiety Disorder (Social Phobia) 300.4 (F34.1) Persistent Depressive Disorder with Anxious Distress, in Partial Remission, Mild Severity 315.35 (F80.81) Childhood-Onset Fluency Disorder (Stuttering)

Note: ¹Diagnoses unknown due to CP1's premature termination

Client-participant 1. Client-Participant 1 (CP1) identified as a 25-year-old, single male of Iranian descent. He reported that he was born in the United States, and that both of his parents, with whom he was living at the time, were born in Iran. CP1 indicated during the intake that he is Muslim; however, during the intake he also stated that he considers himself to be Christian. As an Iranian-American, he considered himself to be very acculturated in the United States. He described that his parents are more traditional than he is; for example, he reported that his parents do not understand why he is employed and receiving commission when he could start his own business or become a professional. At the time of intake, he worked as a junior financial consultant and simultaneously attended college part time to earn his bachelor's degree in Business Administration.

CP1 referred himself for therapy because he wanted to learn to communicate effectively without becoming emotionally over-involved within his work, family, and relationship spheres. He reported that he becomes easily offended and pressured to release his anger. He also described that the experience of emotions and consumption of alcohol contributed to his tendencies to “erupt” with anger, subsequently experiencing an inability to control what he says, which he often regrets due to the hurtful nature of the content of his emotional outbursts. He also described a tendency to shut down and not speak with the person with whom he is angry, all the while maintaining an intense emotional experience of anger. He reported to seek help at the time to learn to communicate more effectively, which can help him in his career, as he no longer wanted his temper to affect his work performance.

CP1 also reported experiencing anger and communication issues with his girlfriend of six months, citing frequent arguments frequent arguments with her. He reported numerous concerns regarding her excessive drinking, lack of motivation, and financial

irresponsibility. He stated that he remains in the relationship due to a genuine interest in her, because she is nurturing, maternal, and is a good person. When discussing his early childhood experiences, CP1 reported feeling resentment towards his mother for leaving him alone in the house to go to work. He also expressed ambivalence with respect to his feelings, in that he believes he cannot be angry with her and still love and respect her for providing for him. CP1 described “brushing off” his mother when she displays affection towards him.

The therapist’s initial impressions resulted in DSM-IV diagnosis of Partner Relational Problem. According to the Treatment Summary, CP1 attended three individual sessions for individual therapy and was terminated after missing two sessions in a row and non-responsiveness to therapist’s phone calls. According to the therapist, during exploration of CP1’s family history, he became defensive surrounding his relationship with his mother and denied that she was a factor in his current conflicts with women. All three sessions were used for transcription and analysis.

Client-participant 2. Client-Participant 2 (CP2) identified as a 32-year-old, Jewish, engaged heterosexual female of Romanian-Iranian descent. During the intake, CP2 reported that while her mother is Romanian and her father is Iranian, she identified with American Jewish culture. CP2 holds a B.A. in Psychology, and at the time of intake, she worked as a clinic director at a behavioral therapy clinic where she also delivered applied behavior analysis services.

CP2 described experiencing a “culture clash” in her household as she was growing up, highlighting that her mother would frequently criticize her father’s Iranian culture and language. As a result, CP2 stated that throughout her childhood she felt ashamed of her Iranian heritage due to constantly listening to her mother berate her father’s culture. CP2 reported that her father

was “not present emotionally,” and that he is a “very nice man, but not deep emotionally.”

Conversely, CP2 highlighted her mother’s overprotective nature and that she felt trapped growing up, especially as she learned to “bottle [her] emotions inside” as a young girl. As a result, CP2 stated that she learned to be hyperaware of her mother’s feelings.

CP2 referred herself to therapy to address interpersonal issues with her mother, sister, and colleagues. Specifically, she reported experiencing irritability and distrust when in the presence of her mother. She described her mother as self-centered and the overall relationship as rocky. With respect to her sister, CP2 reported struggling with growing apart from her sister following her sister’s recent engagement. Further, CP2 described experiencing difficulty addressing conflict at work among her colleagues, specifically following her promotion to clinic director.

During the intake, CP2 described feeling depressed, lonely, and withdrawn from others. CP2 indicated experiencing symptoms of depression approximately one year prior to the intake session, which typically lasted from a few days to a few weeks. During this time, she reported experiencing passive suicidal ideation; however, at the time of intake CP2 denied any current suicidal ideation. According to the therapist’s intake summary, CP2 was unwilling or unable to elaborate on specific periods of depressed mood, both past and present. CP2 stated that her feelings of depression typically began when thinking about her interpersonal relationships, including friendships and intimate relations.

Further, CP2 indicated that she has a fear of formulating new and maintaining close relationships with others. For example, CP2 indicated the last time she experienced distress was during a time when her fiancé was out of town, reportedly experiencing severe distress that prevented her from getting out of bed or leaving the house, which lasted approximately one week. However, CP2 described feeling happy in her current relationship. She reported feeling

respected by her fiancé, whom she also described as smart and sensitive. CP2 reported experiencing stress related to planning her wedding. CP2 stated that she hopes therapy can assist her in improving her interpersonal relationships, acquiring assertiveness skills, learning to navigate stressors, creating boundaries, and to explore her childhood.

The therapist's initial impressions resulted in DSM-IV diagnoses of Depressive Disorder Not Otherwise Specified, Parent-Relational Problem, Sibling Relational Problem, Occupational Problem, and a Global Assessment of Functioning (GAF) score of 70. According to the Treatment Summary, CP2 attended 17 individual sessions for individual therapy. Per CP2's therapist, no significant emergency or crisis issues were evident, and she was respectful and cooperative during the course of treatment. CP2 terminated treatment after indicating that she no longer experienced stressors that warranted the need to continue receiving treatment. While CP2's diagnoses remained largely unchanged from the time of intake, it should be noted that her GAF score increased to 77. For the purposes of analysis, sessions 1, 8, and 16 were transcribed, as these sessions demarcate the beginning, middle, and end of treatment.

Client-participant 3. Client-Participant 3 (CP3) identified as a 36-year-old, Jewish, single male of Iranian and Israeli descent. Born in Iraq and raised in the United States, CP3 described himself of mixed ethnicity and that while he identified with being Jewish, he did not identify with his Israeli or Iranian cultures. CP3 reportedly experienced feeling “like an outsider” and would avoid interacting in social situations with individuals of the Israeli or Iranian communities. While CP3 does not consider himself to be religious, his Jewish identity reportedly played a strong role in his life in terms of adherence to traditional values (e.g., having a Bar Mitzvah, reading Hebrew, and avoiding the consumption of pork).

CP3 reported that his parents experienced marital difficulties due to cultural differences and financial distress, ultimately divorcing after 28 years. CP3 indicated that his mother, who is Iranian, placed a high degree of emphasis on assimilating to the Iranian culture. However, his father felt excluded by individuals from CP3's Iranian side of the family, which reportedly led him to avoid family gatherings. CP3 also described avoiding his Iranian side of the family, due to feeling inadequate and negatively appraised by his family members.

CP3 referred himself for therapy to address symptoms of depression and anxiety as a result of his recent dismissal from a doctoral program in clinical psychology. CP3 reportedly set goals to reduce his anxiety and depressive symptoms, and to develop coping strategies to manage his anxiety and distress. CP3 stated that he also experienced symptoms of depression and anxiety for the past two years as a result of a break-up; however, his symptoms increased following his program dismissal over the past six months. CP3 experienced difficulty sleeping (i.e., interrupted sleep with difficulty resuming), feelings of guilt related to his familial roles, low mood, difficulty concentrating, social isolation, and loss of interest in usual activities.

CP3 reportedly experienced a longstanding history of social anxiety and avoidance. Specifically, he frequently ruminated about fears of criticism or rejection in social situations. As a result, CP3 avoided social interactions, initiating friendships, and feared being appraised negatively due to his stuttering. CP3 also reportedly ruminated about his career trajectory in academia, and worried that he would potentially fail. CP3 stated that he began stuttering at the age of five, which negatively impacted his social and academic functioning; for instance, by eight-years-old, he would often avoid participating in class or engaging with classmates. CP3's stuttering continued into adulthood and were notable during transcribed sessions. Current literature on stuttering reveals a wide range of etiological factors related to the onset of speech

dysfluency (stuttering), such as cognitive abilities, gender, biological, and environmental factors (Prasse & Kikano, 2008). Stuttering is classified into three categories: developmental, neurogenic, and psychogenic. Developmental stuttering, the most common form, typically resolves by adulthood in nearly 80% of children (Prasse & Kikano, 2008). Of the 1% of adults who stutter, 80% of whom identify as males (Prasse & Kikano, 2008). Neurogenic stuttering typically follows a neurological event, such as a traumatic brain injury or stroke (Prasse & Kikano, 2008). Psychogenic stuttering, considered rare, typically occurs in adults with psychiatric history following emotional trauma or a psychological event (Prasse & Kikano, 2008). Regardless of etiology, stuttering can be experienced as stressful and anxiety provoking, further contributing to stuttering (Prasse & Kikano, 2008). Prasse & Kikano (2008) note that anxiety levels among individuals who stutter are specific to the setting and communication situation. Furthermore, individuals who stutter may experience embarrassment, frustration, and stigma (Prasse & Kikano, 2008). Information gathered from CP3's history indicates unresolved developmental onset of stuttering that caused significant anxiety beginning in childhood until present day.

The therapist's initial impressions resulted in DSM-5 diagnoses of Persistent Depressive Disorder with Anxious Distress, Social Anxiety Disorder (Social Phobia), Avoidant Personality Disorder (Provisional), and Childhood-Onset Fluency Disorder (Stuttering). According to the Treatment Summary, CP3 attended 109 individual therapy sessions and three family sessions. Per his therapist, CP3 demonstrated a high degree of motivation to change, was committed to the therapy process, and consistently attended his sessions with minimal cancellations. Termination was collaboratively planned and CP3's diagnoses at the end of treatment remained largely unchanged with the exception of removing the provisional diagnosis of Avoidant

Personality Disorder. Additionally, at termination, CP3's diagnosis of Persistent Depressive Disorder with Anxious Distress was qualified as being in partial remission and of mild severity. For the purposes of analysis, sessions 1, 51, and 110 were transcribed, as these sessions demarcated the beginning, middle, and end of treatment.

Table 2

Client-Participants and Session Numbers Included for Analysis

Client-Participant	Beginning Session Number	Middle Session Number	End-of-Treatment Session Number	Total Sessions
1	0	1	2	3
2	1	8	16	17
2	1	51	110	112

Researcher-participants. One clinical psychology doctoral student was primarily responsible for examining the research data. One masters-level psychology student assisted the doctoral student in the transcription process. The research team was supervised by the auditor of the research study throughout the data collection, transcription, and analysis process. In addition to providing varying perspectives, the inclusion of multiple researchers in the study also helps to minimize biases that may form during the examination of the research data (Mertens, 2015). Personal descriptions of the researcher and auditor are provided in the following paragraphs.

The primary researcher and dissertation author is a Middle-Eastern, female, clinical psychology doctoral student. She conceptualizes and treats clients from both cognitive-behavioral and psychodynamic perspectives. Further, she believes emotional dysregulation is a result of learned inhibition and avoidance of affect, and that the facilitation of emotional expression in the therapeutic dyad will enable symptom reduction.

The secondary researcher of this study was a Caucasian, female, who was a Masters-level student receiving her degree in Marriage and Family Therapy with aspirations to receive her doctorate in Clinical Psychology. Utilizing a holistic approach when working with clients, she mainly uses CBT and Mindfulness treatment approaches. This researcher's previous experience includes case management at a boarding care facility treating individuals with severe mental health disorders. Her primary responsibilities on this dissertation project include transcription and coding of client-participant therapy sessions.

The auditor of this study is a European-American, married, Christian female who possesses a doctoral degree in psychology and a terminal law degree. She is the chair of this dissertation, and a tenured, associate clinical psychology professor whose research interests include forensic and positive psychology, contemplative studies, and the training of new counselors/psychotherapists. She teaches and conceptualizes cases from first through third wave behavioral approaches, and accordingly views emotion work as integral to the therapeutic process. She also has previous experience coding emotional expression and psychotherapy sessions, but not with the specific population of Middle Eastern clients.

Human subjects/ethical considerations. PARC's commitment to ensuring confidentiality of the psychotherapy clients who originally provided informed consent to have their materials placed in the PARC research database was conducted via multiple steps. First, prior to the client's first intake session, each therapist reviewed confidentiality forms with the client as well as his/her option to be included in the research database, to which the client has the option to provide consent for written data and audio and video recordings (Appendix A). Therapists must also have provided their consent to include the data in the research database (Appendix B). If both therapist and client did not consent to the same items, it was not included

in the research database. Following termination, clinic files were placed in the research database where they were redacted to ensure privacy and confidentiality of all participants. Then, research IDs were assigned to both therapist and client for research identification purposes.

Researchers of the study, including coders and transcribers, were required to complete the Institution Review Board (IRB) course (Appendix H), sign a PARC confidentiality statement and any clinic confidentiality statements, as well as engage in clinic training on the Health Protection Insurance Portability and Accountability Act of 1996 (HIPAA) as the database originated in a clinical setting (Appendix I). These added steps are used to ensure that researchers responsible for handling sensitive information are educated about and agree to maintain ethical standards and protect the privacy and confidentiality of participants.

Data Collection, Recording and Analysis

A thorough review of the literature was conducted and synthesized, in order to understand the cultural as well as biosocial factors that underlie how clients of Middle Eastern background exhibit emotion and/or regulate emotion. This information was used to inform the sample selection process and creation of the coding manual (Appendix G). The coding process is described below in the Data Analysis section of this chapter.

Sample selection. The study utilized archival data from the psychotherapy files of three client-participants who met the study's inclusion and exclusion criteria from the Pepperdine Applied Research Center's database of terminated sessions at two of GSEP's community counseling centers. The sampling selection method chosen was purposeful sampling, and the data collection steps were as follows:

First, the researcher began the sample selection process by examining the hard copy research files in the University clinics. She began by identifying adult clients through selecting

the files with research numbers indicating that fact. Next, she reviewed forms in the research files that indicated the client's race/ethnicity as being of Middle Eastern descent: Armenian, Bahraini, Egyptian, Iraqi, Jordanian, Kuwaiti, Lebanese, Omani, Palestinian, Qatari, Saudi Arabian, Syrian, nationals from the United Arab Emirates, Yemeni, Israeli, Afghani, Turkish, and Iranian. Specifically, she examined the Social/Cultural section of the Client Information Adult Form (Appendix D), the Identifying Information, Psychosocial History, and Cultural Factors and Role of Religion sections of the Intake Evaluation Summary (Appendix E), and the Identifying Information section of the Treatment Summary (Appendix F). A total of 69 files available for research were examined, and only six client files identified as Middle Eastern.

Second, of the six cases identified as Middle Eastern, only three cases were selected based on availability of working recorded psychotherapy sessions. Three sessions were selected per client. The rationale for examining up to three sessions was to obtain a sense for how emotion regulation or dysregulation is manifested during treatment by Middle Eastern clients across time. Researchers selected sessions from the beginning, middle, and final stages of treatment. However, one client-participant only attended a total of three psychotherapy sessions; thus, for this case researchers transcribed and coded back-to-back sessions, a potential limitation when comparing and contrasting effects of psychotherapy across time.

Third, while the original intention of the study was to obtain a split sample by gender, only three files were selected due to availability and functioning of working DVDs. Thus, of the three available files, two participants identified as males and one as female. Further, of these files, two clients identified as Jewish and one participant identified as both Muslim and Catholic. In total, nine therapy sessions were transcribed and coded to account for the three participants selected.

Transcription. Sessions were transcribed and redacted by one masters and one doctoral level psychology graduate students at Pepperdine University. The researchers learned Baylor University's Institute for Oral History's system for transcribing therapy sessions. Specific transcription instructions are located in The Coding Manual (Appendix G). Coding procedures are discussed above in the instrumentation section.

Data recording. Transcribed sessions were recorded into Excel sheets. Duplicate copies of transcribed sessions were created for both researchers. Each Excel sheet contained columns for Emotion Regulation, Emotion, and InVivo codes. A column for researcher notes served as a place for researchers to note observations from video sessions, as well as thoughts and reactions to the session content. After sessions were coded, the primary researcher merged both researchers' data sheets to observe agreements or disagreements in coding. This sheet was then reviewed by the auditor of the study, and agreements for codes were finalized after several passes through the data.

Data Process and Analysis

In order to understand patterns and themes of emotion regulation and dysregulation among clients of Middle Eastern descent, a qualitative inductive content analysis approach in a naturalistic setting was utilized. Coding was conducted by the primary researcher and graduate research assistant who were supervised by the research supervisor, serving as the auditor for the study.

Following the procedures in the Coding Manual (Appendix G), coders first practiced coding by reading past research and reviewing coding schemes. They reviewed didactic materials on inductive content analysis, as well as particular themes, concepts, and issues to be mindful of when coding, as described in the Coding Manual (Appendix G).

Given the literature detailing inhibition/suppression of affect and negative emotional expression among Middle Eastern Americans (Abdulla & Brown, 2011; Al-Krenawi & Graham, 2000; Dwairy and Van Sickle, 1996; Haboush, 2005), this qualitative analysis of emotion regulation among Middle Eastern Americans also sought to understand specific emotional content of psychotherapy sessions for each client-participant. Using inductive content analysis, researchers in this dissertation study uncovered specific emotions expressed across client-participants. Emotion coding was grounded in a list of emotion definitions created by the researcher and auditor based on Linehan's list of emotions and other sources from the literature (see Appendix H). Further, the researchers labeled each coded emotion as either expressed (explicitly named by the client) or inferred (identified by the researchers) during client talk-turns across each session for each client-participant. Analysis of the emotion codes including comparing expressed and inferred labels (see Appendix K), and active comparison of them the aforementioned parent themes of *Emotion Regulation* and *Emotion Dysregulation*. Lastly, emotion codes were also categorized as positive or negative, with the exception of the *Surprise* emotion code, as *Surprise* categorically could have either a positive or negative valence (Noordewier & Breugelmans, 2013).

Then, they practiced coding on two practice cases to test their understanding of the coding process and as a way to establish initial inter-rater reliability, with a predetermined goal of 66% agreement. Coders reached 86% agreement following practice coding, which was substantially greater than the original goal of 66%. While interrater or intercoder agreement can be a helpful way for researchers to remain consistent in coding data, Saldaña (2009) as well as Harry, Sturges, and Klinger (2005) state that researchers may rely on group discussion to reach consensus and agreement. Thus, this approach was also used, as discussed below.

The target person coded was the client-participant. The unit of coding was a client's talk turn, which is defined as words, phrases, or sentences said before or after a therapist verbalization. During each talk-turn, expressed and inferred emotion, verbal instances of emotion regulation, and unique phrases, metaphors, repetitions were coded.

Following practice coding, coders reviewed the video sessions and the transcript from those client-participant sessions independently to avoid potential biases that may negatively impact coding. The researchers read the entire transcript and identified InVivo, Emotion, and Emotion Regulation codes. The Emotion Regulation codes reflected both the ability to regulate emotions as well as instances revealing past or present difficulty regulating emotions.

First cycle coding. Several coding cycles can be utilized during an inductive coding approach (Saldaña, 2009). For this study, the First Cycle coding method involved the use of three coding approaches to carefully examine the data as they pertain to the research questions. First, researchers coded the data utilizing the InVivo Coding method, also understood as "literal coding" and "verbatim coding," as this method utilizes the participants' language verbatim (Saldaña, 2009). As this study sought to examine how Middle Eastern Americans in psychotherapy regulate emotions, the InVivo Coding approach allowed the researchers to code the participants' actual words in order to preserve the participants' voices, as well as to understand their world views and cultures (Saldaña, 2009). This approach is helpful to capture specific nuances and cultural metaphors, as well as specific behaviors that illuminate how client participants regulate emotions in sessions (Saldaña, 2009). Ultimately, InVivo coding was not used to form specific codes or parent themes because the researchers determined that the Emotion codes more directly addressed the research questions pertaining to the client-participants' experiences and expression of emotions in their own words. Nonetheless, InVivo

coding provided a useful tool to qualitatively review the client-participants' nuanced communication, and was reflected as overlapping with some of the Emotion Coding.

Emotion Coding, the second coding approach utilized during the First Cycle Coding method, enabled the researchers to code specific emotions identified, recalled, or experienced by the client participant (Saldaña, 2009). Emotion Coding also allowed the researchers to infer specific emotions experienced by the participant (Saldaña, 2009).

Emotion Regulation Coding, the third yet related approach to the Emotion Coding process, allowed researchers to identify how clients engaged in a variety of strategies, such as emotional suppression, avoidance, impression management, and emotional denial (Saldaña, 2009). Given that the study sought to identify how Middle Eastern American psychotherapy clients regulate emotions in session, Emotion Regulation Coding enabled researchers to identify the subjective emotional experiences of the participant (Saldaña, 2009). Coders also created notes in a separate column to justify emotion regulation codes based on current literature's understanding of emotion regulation strategies. Coders discussed their results together after several passes through the data. While this was still an inductive process, some might argue that the researchers used a deductive lens when examining instances of emotion regulation/dysregulation as their coding was informed by the literature and they explicitly coded for emotion regulation/dysregulation.

Next, coders shared the results with the study's auditor. Because the goal, as utilized by Harry, Sturges, and Klinger (2005), was to reach consensus, interrater reliability was not computed. Following the auditor's review of the audit trails and codes, and after multiple discussions and review of findings, consensus of codes was reached prior to finalizing the codes.

Based on these finalized codes, the primary researcher coded the units into categories during the Abstraction and Categorization process.

Abstraction and categorization. The next coding approach involved the primary researcher independently grouping similar codes and creating general categories based on these similar codes. Once the concept groups were formed, the researcher organized these groups hierarchically into categories. These sub-themes were organized under what the researcher then identified as Parent Themes, or theme titles that described several concept groupings (Elo & Kyngäs, 2008). During this process of abstraction, the researcher moved back and forth between hierarchical concept levels (codes, concept categories, and parent themes), consistently referring back to the research questions (Elo & Kyngäs, 2008).

The primary researcher then submitted themes and abstracted codes to the auditor, who also reviewed the researcher's steps and notes in the audit trail. This step of reviewing data and researcher's notes allowed for the dependability and confirmability (Zhang & Wildemuth, 2009). The auditor offered feedback regarding the creating of abstracted codes, sub-categories, and Parent themes. The primary researcher then utilized this feedback to edit codes, sub-categories, and Parent themes. After further review codes were finalized by the auditor.

As part of the analysis process, the researcher placed categorization findings into tables and figures via Excel. These finding were then compared against existing literature, as well as new literature obtained following ongoing literature search process to update and expand relevant and needed areas.

In order to maintain accuracy and transparency (Mertens, 2015), an audit trail was utilized throughout the process, which included and described decisions that were made regarding the research design, data collection, analysis, and reporting as well as personal

reflections and biases (see limitations section for notes on biases). Further, bracketing, a method used in qualitative research to reduce negative effects of preconceived notions held by the researcher in the study, was employed (Tufford & Newman, 2012). Bracketing procedures include writing memos during data collection to reflect upon the researcher's connection with the data, interviewing outside sources to process and uncover potential biases that may arise during data observation, and creating a journal to facilitate the expression of possible biases that may generate during the process (Tufford & Newman, 2012). The primary researcher and research assistant independently kept journals where thoughts and feelings were recorded as a way to reflect upon data collection and analysis, so as to minimize bias that could potentially affect the research process.

Chapter 4: Results

This study investigated the ways in which Middle Eastern Americans expressed and regulated emotions and/or revealed existing emotion regulation strategies 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, which addressed the research questions for this study: (a) How are emotions expressed by Middle Eastern Americans in psychotherapy? and (b) How are emotions regulated by Middle Eastern Americans in psychotherapy?

This chapter begins with an overall description of the emergence of Parent Themes related to emotion regulation across participants. Next, a description of unique session content, including emotion and emotion regulation themes that emerged within each client-participant's sessions are presented. The review of within-participant themes and emotional content captures the nature and nuances of each client-participant's unique interactions and therapeutic dynamics unfolding in the psychotherapy setting.

Overview

Of the nine psychotherapy sessions (representing three sessions across a course of individual treatment for three client-participants) that were reviewed and coded in the present study, all nine sessions were coded as containing content relevant to positive and negative emotions, emotion regulation and emotion dysregulation. Two highest-level Parent Themes were generated inductively from the open coding, abstraction, and categorization process (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005; Saldaña, 2009), and represented themes that emerged across all client-participant sessions (see Figure 1). Specific examples from the therapy transcripts are provided to illustrate the concepts at each of these levels.

Further, as part of the abstraction and categorization process, the number of occurrences of each code/initial theme within each session was calculated and recorded (see Appendix J). Specific emotions were also coded and counted for each session and each participant (see Appendix K). Generally, qualitative content analysis does not focus on frequency and statistical significance (Saldaña, 2009); thus, these calculations were not used to explain themes. Rather, for the purposes of this study, they were used to track codes within and across the context of multiple sessions and as one indication of their salience.

Lastly, cultural dynamics were noted by the researchers during the coding process and are presented in Section 3: Within-Participants Findings section. When highlighting session content, ellipses (i.e., ...) indicate that some session material was omitted when providing the transcribed examples, as it was considered extraneous for the illustration of such dynamics.

Section 1: Parent Themes Across Participants

To address the second research question: How are emotions regulated by Middle Eastern Americans in psychotherapy?, inductive content analysis of nine psychotherapy sessions yielded two Parent Themes, consisting of three categories, or sub-themes, per Parent Theme, which reflected commonly occurring ways that the client-participants used to attempt to regulate their emotions (see Figure 1). The Parent Themes identified were Emotion Dysregulation and Emotion Regulation. The Emotion Regulation Parent Theme consisted of three categories: (a) Experiential Avoidance, (b) Negative Emotional Reactivity, and (c) Difficulty Labeling current/present Affect. The Emotion Regulation Parent Theme also was comprised of three categories: (a) Acceptance, (b) Increasing Positive Emotional Events, (c) Labeling Affect In The Moment. Each of these Parent Themes and their categories are defined and described next.

Further, Emotion Regulation and Emotion Dysregulation Parent Themes and corresponding categories are defined in Appendix I.

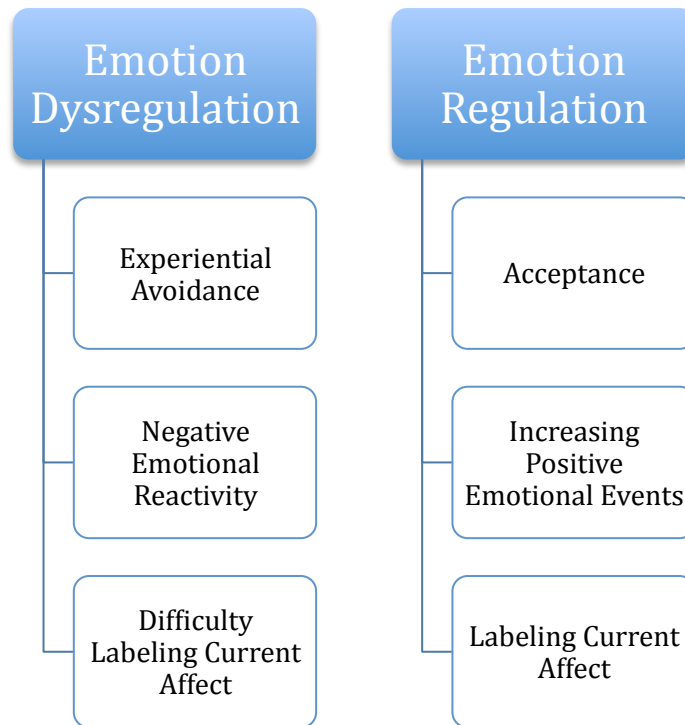


Figure 1. Parent themes and corresponding categories across client-participants

Emotion dysregulation. The Emotion Dysregulation theme was defined as the use of maladaptive regulation strategies, lower emotional awareness, and/or the inability to inhibit or regulate distressing emotions, as evidenced by session processes or by the client-participant's revelation of existing maladaptive regulation strategies, all of which appeared to affect the client-participant by eliciting a negative and/or maladaptive internal or external reaction. The Emotion Dysregulation theme was comprised of three categories of codes ($n = 109$) that were present among all client-participants: (a) Experiential Avoidance ($n = 82$), (b) Negative Emotional Reactivity ($n = 19$), and (c) Difficulty Labeling Current Affect ($n = 8$) (see Appendix J and Figure 2 below).

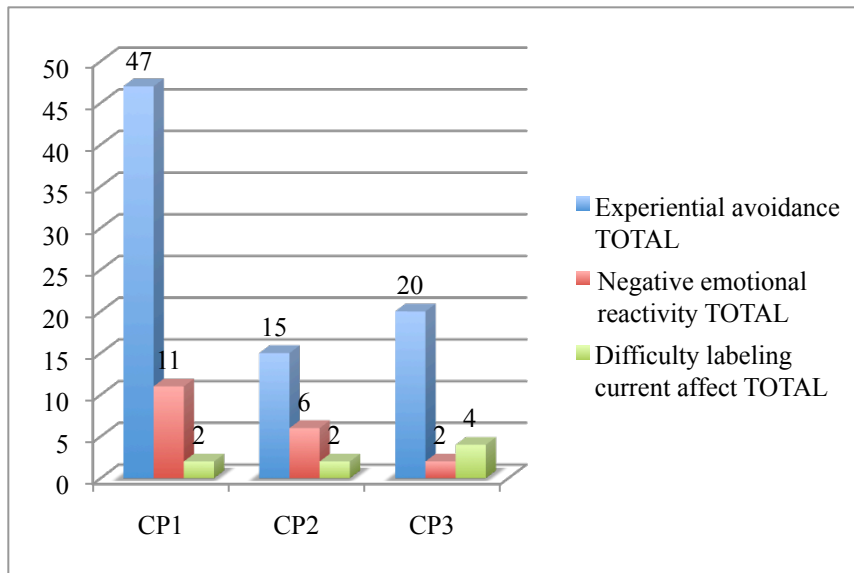


Figure 2. Total emotion dysregulation codes across client-participants

Experiential avoidance. All client-participants described either existing or in-the-moment instances of experiential avoidance. This study defined *Experiential Avoidance* in accordance with its use in the literature, namely how a client-participant attempted to avoid thoughts, feelings, inner emotional experiences, physical sensations, and/or memories, and/or engaged in behaviors to avoid these specific situations and contexts (Blackledge & Hayes, 2001). Of the nine transcribed psychotherapy sessions, the *Experiential Avoidance* category was coded 82 times in client-participant statements. Client-Participants used a variety of ways to avoid internal experiences, including substance use, emotional eating, avoiding interpersonal relational dynamics and stressors, isolation, avoiding experience of negative emotions, suppression of emotion, as well as in-session dynamics that highlighted client-participant's strategies to avoid exploration or direct confrontation of emotion. The example below highlights CP1's difficulty with exploration of negative affect, and illustrates how he moved away from the experience of emotion in session #2, his last treatment session:

- T19: How do you feel about just allowing yourself to be angry? Is that even an option?
- C19: To allow myself to be angry? I wouldn't want that if that. If that were to be the case. Why would I want to be angry at her? What's been done is done. It's in the past. I'm grown up so-
- T20: Yeah but it's still coming up it's still hurting you. You feel like you can't even talk to her.
- C20: She's just too much. She's too lovey dovey. Maybe part of me feels like it's too late and I just shut off. At the same time I know it hurts her so it's not right to repel against that because it only hurts her so much more.

In another example of *Experiential Avoidance*, in session #16, CP2 revealed the avoidance of directly confronting her therapist about her wishes to terminate therapy, as she ended session early and cited new concerns that she felt the need to return to work. It should be noted that this was CP2's last session in treatment, as she terminated with therapist after this session.

- T83: We have about ten minutes until your parking meter goes buy so I'm going to leave it open to you.
- C83: Okay um I don't know. I don't really have anything on my mind. Would it be okay if we ended the session early?
- T84: If that's what you want to do?
- C84: The only reason is I feel like I probably should get back to work because I had to miss the morning for my doctor's appointment this morning. So, I'm wondering if I should cut the session short.
- T85: That's fine. Do you want to tack on an extra ten minutes next time and do a full hour?
- C85: Okay, yeah that would be great.
- T86: Alright.
- C86: Yeah, if we feel like we need it.
- T87: Yeah, sure, sure.
- C87: Yeah, I feel like - I also have it in the back of my mind that I'm missing a lot of work today and that I should probably get back.

In our last illustration of *Experiential Avoidance*, in session #1, CP3 revealed how he avoids interpersonal relationships stemming from his core belief of feeling weak:

- C37: For example, I see a group of Persian people my age or younger than me. I don't there- but also they speak Farsi, too. But I don't get it. Israeli is the same way. I don't get it. 100% white American - I don't get it. Obviously, Asian I don't get it. There's not one group of people I just get at all.
- T38: Mm-hmm

- C38: I don't know if that's because – maybe, if I had a group of friends, a consistent group of friends that would be the same? I don't know. At times I also feel like I'm not worthy as well.
- T39: Mm-hmm. Like worthy to fit in what category?
- C39: Yeah I feel like if people get to know me. I know it's wrong. This is why it's tough because I was educated and experienced in this field. I know I can receive some type of - even just self-therapy. Look at things differently. Test things out. I understand that. It's just the way I feel. Yes I feel like if people got to know me - I'm afraid to be weak around them. I keep people at like an arms-length away.
- T40: Mm-hmm
- C40: Because I don't want to be perceived as weak. Because, if I'm weak then I won't be respected. (4 second silence) So I keep people at an arms-distance and then I wonder why it's hard for me to relate to people. I know $1+1=2$. I understand that but sometimes it just bothers me.

Negative emotional reactivity. Negative emotional reactivity, evidenced across all client-participant sessions, was defined for the purposes of this study as heightened adverse emotional response to environmental or internal stimuli. The *Negative Emotional Reactivity* category was coded 19 times across client-participants, and revealed a variety of ways in which client-participants negatively responded to internal or external stimuli, past or present. In the example illustrated below, CP1 (session #0) describes his reactions to conflicts and emotions:

- T8: Um, great. Oh, I wanted to talk to you about the history - kind of - of the reason that you're here. When was the first time – you, you spoke about being angry and, having problems with communication. How long has that been going on?
- C8: [Scratches nose, looks down] It's been a long – it's been a long time. I don't know how to cope with conflicts and emotion. So, things steer the wrong way, I'm not the best at trying to straighten it out.
- T9: What would be the wrong way?
- C9: Overreacting. Commenting without rationalizing or thinking. Getting caught up in the emotional frustration. Uh, [Looks up] within my inner self. And kinda regurgitate out without thinking of the other person or the situation. I overreact. I tend to overreact with my emotions. [Gestures with hands as he speaks].
- T10: Is there a particular trigger that gets you that angry?
- C10: It's not a particular – I just get irritated fast. And I don't like to deal with it.
- C11: It could be anything. It's just nothing specific. [looks down]. You know, um, it just, if I get irritated, I'll just shut off and walk away instead of trying to confront that situation and talk it out like a normal person.

The example above also revealed another example of *Experiential Avoidance*, as CP1 described his typical responses (e.g., walking away) to negative and emotionally provoking stimuli. It also demonstrated how he was capable of reflecting on more adaptive ways of dealing with conflict, albeit describing his inability to be “like a normal person” in a self-stigmatizing manner.

In a second example of *Negative Emotional Reactivity*, CP2 illustrated her response to feeling frustrated and vulnerable in session #8:

C70: ...And yeah yesterday the news was kind of bad and so when [Fiancé] called me and started telling me about it I started tuning him out. I couldn't concentrate on what he was telling me. But at the same time, as soon as I heard it was bad news, it just threw me over the edge. I started crying like out of frustration. And the night before that I had a decent day and then [Fiancé] started talking about something that was negative. And I feel like so vulnerable. Like, if I feel good it's so easy for me to fall back and feel badly again.

In our last example of this category, in session #51, CP3 revealed a specific instance of negative emotional reactivity, which he linked to feeling irritable:

C92: My mind is very cloudy right now. Cloudy. Yeah, cloudy I guess is good. I guess it means I'm lacking concentration. This is decaf by the way [points at coffee cup] So, I can't blame caffeine for how I am feeling.

T93: Yeah.

C93: You know, even though everything is crazy, you know three weeks ago when shit was crazy [sigh] I was way more irritable. So I'm not as irritable but I'm more worried. More anxious. Less irritable now. So if I was drinking caffeine this week it would have been a horrible week for me. So yeah this is the product, I just do not know. I don't know what to say. I don't know what to do here. I don't know what I want to achieve here. Um, I do like coming here. Um but I just don't know what to do. I don't know what to do out there. You know once in a while when I'm when I'm giving a lecture I'm writing on the board. Let's say using a market on the white board. For a split second I stop, like what the fuck am I doing right now? Who am I? And then I'll just keep writing.

T94: Mhm. Right.

C94: When I walk – when I walk into class I just had this angst, this irritability of being there and then as the lecture starts, yeah, last week, Mon-Monday of this week first class I taught this week I went in and I was very irr-irritable and then people were talking and then I just gave it to everybody. It felt good though. Immediately everybody [sits up puts hands close to self to mimic alertness of students] they were like, “Oh shit.” Maybe that's a good thing right? [rubs eyes]

Although CP3 was able to identify his feelings of irritability, as well as his related emotional response, he was unable to cite a specific stressor. This also represented a missed opportunity by the therapist to help CP3 identify situational triggers to his emotions and behavioral responses.

Difficulty labeling current affect. Across all nine sessions, all three client-participants revealed difficulty labeling affect in the present moment ($n = 8$). For the purposes of this study, *Difficulty Labeling Current Affect* was defined as the inability to identify, label, and distinguish emotions. The *Difficulty Labeling Current Affect* category was coded eight times across all nine sessions. In the example below from session #2, CP1 was seen as attempting to define his emotional experience:

C149: It's not the commitment. I think a little bit of both. My fear is - I did a little bit of math. It's going to cost me about \$2500 a month just to pay the mortgage [rubs face] and you got TV and all the miscellaneous stuff to add to that. And it's a lot. And my moving out is very um, it's based on my me getting another promotion by January. So, um, I don't want her to think she can move in and oh I don't have money this and that and put that burden on me. I will get really furious. I mean I'm not expected to charge her month. But she's gotta pull her weight. It's not charity. I would bust my ass so she can bust my ass and watch tv. And um also, I forgot what I was gonna say, so sorry I forget. [laughs]

In this example, CP1 began to identify an emotion (fear); however, he quickly moved away from exploring affect and described financial stressors without linking them to his core emotion. In another illustration of *Difficulty Labeling Current Affect*, CP2 revealed her difficulty with identifying her emotions in session #1:

C1: So, I was having some, not concerns but stress about therapy and the same kind of stress that I think I've had in the past. I'm not quite sure, like when I'm in a good space, generally during the day when it's a workday and I'm focused. It's hard for me to extract my emotions and thoughts of what's bothering me or what the issues are otherwise.

For CP3, he revealed several instances of feeling confused about his emotions, and was unable to identify specific emotion states in the examples below:

C23: Um, I feel lost. I think. Not I think. I know. I just feel. I – I am lost. Forget I feel. I'm just lost. I don't know what I'm what I'm doing. You know. Um I have a lot of other things that made me feel like I wasn't lost. Like, I have this lawsuit.

In the same session (#51), CP3 also revealed difficulty with labeling affect, and began to laugh in an attempt to regulate his discomfort, as illustrated below:

T46: Okay. So what would that look like for you then? Like how would you conceptualize that for yourself?

C46: [laughs] I have no idea. I don't know why I'm laughing. That made me laugh for some reason.

Emotion regulation. The second Parent Theme derived during the inductive content analysis was *Emotion Regulation* ($n = 35$). It was defined as how the client manages his/her emotions by flexibly and adaptively responding to negative emotional experiences. The *Emotion Regulation* theme is comprised of three categories of codes that were present across all client-participants: (a) Acceptance ($n = 12$), (b) Increasing Positive Emotional Events ($n = 6$), and (c) Labeling Current Affect ($n = 17$; see Figure 2 below).

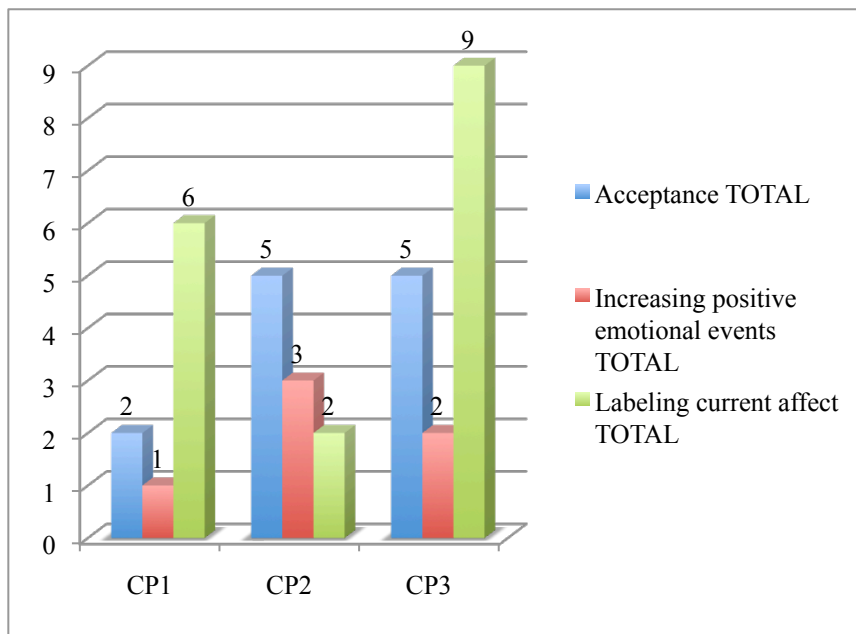


Figure 3. Total emotion regulation codes across client-participants

Acceptance. All client-participants sessions revealed codes for *Acceptance*, which was defined as acknowledgement of emotional, situational, or environmental difficulties without attempting to escape or avoid the respective situations. The *Acceptance* category was coded 12 times across the three participants and nine psychotherapy sessions, and varied across participants. For CP1, this was illustrated in his acknowledgement and acceptance of situations, as seen below from session #1:

C47: [looks down, sighs]. Umm, well, ever since I got into a relationship not as much. But um, I mean, that's just the way it goes. But I stay in contact with them. Yesterday was a birthday party of my friend's girlfriend so we all got together so. It seems like the only way these days you get people around – birthday or an event. So...[nods head] Not as much as you like, but it's just the way it is. You work. You have your own life to deal with now.

In another example of *Acceptance*, in session #1, CP2 demonstrated how she has come to recognize, accept, and move past difficult situations:

C43: Right, right. And I think I've worked through a lot of that stuff with [Fiancé]. In previous relationships somebody does something that's hurtful and I don't even know how to talk to them afterwards. Now it's like okay you said that and that's okay.

T44: Right

C44: And you move past it. Accept it.

Acceptance was also seen as recognition and tolerance of one's own limits to stimuli that are emotionally provoking. In session #16, CP2 described this newly acquired process:

C69: Every time I get a stressful email I put it aside for a second and try to process it. I try to remind myself that I can't control everything. It's been helpful.

Further, *Acceptance* was also seen by acknowledgement of one's current situation and acceptance of limits. This was illustrated towards the end of CP3's last coded session (#110):

C156: I feel like that- I'm heading towards peace. Not a 100% peace but I'm heading towards there. Acceptance more so than peace.

T157: Mm-hmm

C157: With the occasional struggle here and there but that's being a human being.

Increasing positive emotional events. For the purposes of this study, *Increasing Positive Emotional Events* was defined as utilization of positive coping to facilitate emotional regulation. While all client-participants revealed relatively few codes for *Increasing Positive Emotional Events* ($n = 6$), CP1's transcribed sessions revealed only one code for this category. For CP1, his sole use of *Increasing Positive Emotional Events* was revealed by how he positively described and valued his friendship circle.

- T45: Do you feel like you have that now? That kind of friendship circle that you wanted?
C45: Yeah, everyone in my life. They're great. Good-hearted people. Come from good families. Educated. Very determined. Very well oriented. So, yeah I do. I do.
T46: Mm, you value those people?
C46: Mhm [nods head yes].

While CP1 only revealed one code in this category, CP2 and CP3 identified different coping skills they used to increase their positive emotional states. For instance, in CP2's 8th session, she showed how she would use coping skills to increase positive mood:

- C38: I was even telling [Fiancé] in the past few years when I would feel this I would do things to make myself better. I would watch movies or sleep a lot for like a weekend. I would isolate myself and then I would be ready to come out and I would okay. Or listen to good music and exercise.

CP2 also discussed ways to increase positive mood by using relaxation exercises:

- C148: Definitely, cause I do take the deep breathes but not like that. People get scared of me they're like uh-oh she's upset. [Client laughs]

Similarly, CP3 also described using physical exercise to promote positive mood:

- C131: To my fighting activities. The exercise I, I, I still do. You know so maybe it's not 100% but it's usually close to it, like just in terms of being in the home, going to the gym, working out, that 45 min to an hour or whatever...Because there's a lot of social interaction to everything. You're interacting with people while you're training. That takes a little more out of you. It takes more of uh a kicking in the butt for me. But every time I'm there, I'm like, I, I, I love it! I need to capture that ...

CP3 also demonstrated in session #110 how he learned to positively change his cognitions about certain situations to promote positive mood:

C82: Yeah because when these things happen I kind of have to make it enjoyable. I'm not going to be in the corner [client demonstrated pouting] you know what I mean? I'm going to be me.

Labeling current affect. Variations in identifying emotional experiences among the three client-participants appeared across all nine transcribed psychotherapy sessions. The *Labeling Current Affect* category was described as the ability to identify and express emotions experienced in the current moment. According to DBT, the ability to identify emotions experienced and to label them is a crucial component of emotion regulation (Carpenter & Trull, 2013). The *Labeling Current Affect* category was coded 17 times across the three participants, and the frequencies differed substantially across client participants (CP1, $n = 6$; CP2, $n = 2$; CP3, $n = 9$).

Examples of this category can be seen in CP1's sessions #s 0, 1, and 2, respectively:

C110: I feel ashamed. Like why does she do that?...Um it bothers me because, one, I'm a respected person. Two, you're a reflection on me too. Like I don't want people whispering behind my back. Not like I care - this is my relationship. This is what it is. Respect it. I don't like the fact that she has to rely on something. So, it bothers me that she doesn't have enough self-control and confidence to kind of push it away. Or did. Um, and sometimes she forgets that. So that's what kinda bothers me.

C80: Little more stressed. I don't want to go out, don't want to hang out. Go to parties. I feel like I should be studying. So, I feel I'm a little more extreme.

C197: Because - I don't know. I mean some of it was my fault. I don't have the balls to tell her, "You know what? I'm gonna hang out with the guys" 'cause I'm afraid of what she's gonna say, so...

For CP2, on the other hand, while she was able to describe experiencing "fear" of talking to her mother, she simultaneously noted the difficulty she faced with being direct with her emotional experiences with her mother.

C37: I'm watching how [Fiancé] interacts with his mom and it's such a healthier way to deal with things. Just say it and get it out there. But there's such a fear with me and my sister with talking to my mom. Because you say it and you're dealing with the wrath of her for the next week. We've been like - basically our behavior has been punished.

Another example highlights how CP2 was able to label her emotions in the present moment; however, she followed this affect recognition with laughter, possibly indicating discomfort or simultaneous experiences of emotion regulation and dysregulation.

C91: Not really. She went to Puerto Rico on vacation for a few days. And then she emailed me saying "Hey I'm back how's your neck?" because of the accident. "Let's talk about the schedule for when you're here." I'm just like mad at her. [Client laughs]

Other examples of affect labeling occurred in higher frequency in CP3's sessions. In session #1, CP3 detailed his emotional experience in the moment:

C132: [Nods head] Every time. Every time. I - uh. Every time I think about my - my - my mom, for example. Uh, like one example is this whole Thanksgiving thing, right? She knows I'm not going to be there. But it's embarrassing that I have to tell her. Thirty-six year old guy. I just don't want to be there 'cause I just have too much on my mind. I don't feel like dealing with all these people right now. You know, there's a little bit of guilt in me. But I think of the alternative, and I don't want to be there. And I'm very embarrassed about that. Extremely...

For CP3, session #51 revealed an increased ability to label affect in the present moment. In this session, he was able to label his emotional experience in session with more frequency than in sessions #1 and #110. Examples include:

C29: Exactly. And I'm getting scared right now cause I'm - I'm lost. I'm lost.

C47: I don't know. Cause in a way this - this is all big joke to me. This is my cranky side right now [laughs] this is my irritable -

C81: That I have a fear of rejection and being walked all over. Yes.

C93: You know even though everything is crazy, you know three weeks ago when shit was crazy [sigh] I was way more irritable. So I'm not as irritable but I'm more worried, more anxious. Less irritable now...

C102: And now what right? Exactly. And now I feel tired. Bummed down still from time to time. Beaten down...

C113: I feel weird at this moment. Talking about what I talked about with you at this moment. I feel weird. It's a weird thing to say. First time I have clarity. [laughs]

Summary. Inductive content analysis of the nine transcribed psychotherapy sessions yielded two Parent Themes of *Emotion Dysregulation* and *Emotion Regulation* that answered the research question “How are emotions regulated by Middle Eastern Americans in psychotherapy?” The *Emotion Dysregulation* theme comprised of three categories: *Experiential Avoidance* ($n = 82$), *Negative Emotional Reactivity* ($n = 19$), and *Difficulty Labeling Current Affect* ($n = 8$). The *Emotion Regulation* theme was also comprised of three categories: *Acceptance* ($n = 12$), *Increasing Positive Emotional Events* ($n = 6$), and *Labeling Current Affect* ($n = 17$).

Section 2: Emotion Coding Results

Given the literature detailing inhibition/suppression of affect and negative emotional expression among Middle Eastern Americans (Abdulla & Brown, 2011; Al-Krenawi & Graham, 2000; Dwairy and Van Sickle, 1996; Haboush, 2005), this qualitative analysis of emotion regulation among Middle Eastern Americans also sought to understand specific emotional content of psychotherapy sessions for each client-participant. Using inductive content analysis, researchers in this dissertation study uncovered specific emotions expressed across client-participants.

Addressing the first research questions for this study, “How are emotions expressed by Middle Eastern Americans in psychotherapy?”, a total of 12 emotion categories were created and defined during the inductive content analysis: *Anger, Happy, Pride, Love, Discomfort, Surprise, Fear, Sadness, Shame, Stress, Guilt, and Hopefulness*. Positive emotions included *Happy, Pride,*

Love, and *Hopefulness*. Negative emotions included *Anger*, *Discomfort*, *Fear*, *Sadness*, *Shame*, *Stress*, and *Guilt*. Further, synonyms for each emotion category were provided as examples in the Emotion Code Definitions Manual, which provides definitions for each emotion coded (see Appendix H). This list of emotion definitions was created by the researcher and auditor based on Linehan's list of emotions and other sources from the literature. Further, the researchers labeled each coded emotion as either expressed (explicitly named by the client) or inferred (identified by the researchers) during client talk-turns across each session for each client-participant.

Specific emotions expressed or inferred by client participants were grouped under the respective emotion categories (Appendix K). All client-participants revealed emotion codes for *Anger* ($n = 128$), *Happy* ($n = 29$), *Discomfort* ($n = 9$), *Fear* ($n = 81$), *Sadness* ($n = 35$), *Shame* ($n = 42$), *Stress* ($n = 38$), and *Guilt* ($n = 16$). CP1's sessions revealed *Pride* ($n = 2$) and *Love* ($n = 4$) across all three psychotherapy sessions, whereas CP2's and CP3's transcribed sessions did not reveal either of these emotions. CP1 and CP3 revealed *Surprise* ($n = 5$) in their transcribed sessions, and, CP3 was the only client-participant who endorsed *Hopefulness* ($n = 1$) during his first transcribed session.

Inferred versus expressed emotions. As previously mentioned, inductive content analysis of the emotion codes included analysis of inferred and expressed emotions. Emotions were coded as *inferred* by the researchers informed by the content of client-participant talk turns. Emotions coded as *expressed* were emotions that were explicitly stated by the client-participant during the talk-turn.

The most frequently coded emotion was *Anger* (inferred, $n = 72$; expressed, $n = 52$), followed by *Fear* (inferred, $n = 46$; expressed, $n = 35$), *Shame* (inferred, $n = 27$; expressed, $n = 15$), *Stress* (inferred, $n = 19$; expressed, $n = 19$), *Sadness* (inferred, $n = 24$; expressed, $n = 11$),

Happy (inferred, $n = 22$; expressed, $n = 7$), *Guilt* (inferred, $n = 9$; expressed, $n = 7$), *Discomfort* (inferred, $n = 6$; expressed, $n = 3$), *Surprise* (inferred, $n = 3$; expressed, $n = 2$), *Love* (inferred, $n = 2$; expressed, $n = 2$), *Pride* (inferred, $n = 1$; expressed, $n = 1$), and *Hopeful* (inferred, $n = 1$; expressed, $n = 0$). Frequency counts for emotions expressed and inferred are provided in Appendix K. By categorizing emotions as inferred or expressed, researchers were able to compare the differences between the emotional content of sessions that was not expressed over emotions that were expressed, as the assumptions in the current literature with this population indicate that emotions are typically inhibited or suppressed (Abdulla & Brown, 2011; Al-Krenawi & Graham, 2000; Dwairy and Van Sickle, 1996; Haboush, 2005).

Lastly, emotion codes were also categorized as positive or negative, with the exception of the *Surprise* emotion code, as *Surprise* categorically could have either a positive or negative valence (Fontaine, Scherer, Roesch, & Ellsworth, 2007; Russell, 1980).

Positive and negative emotions across client-participant sessions. Across all client-participants and his/her respective sessions, the majority of emotions coded fell under the Negative Emotions category ($n = 349$). Positive emotions were coded with substantially less frequency ($n = 36$). See Figure 4 below.

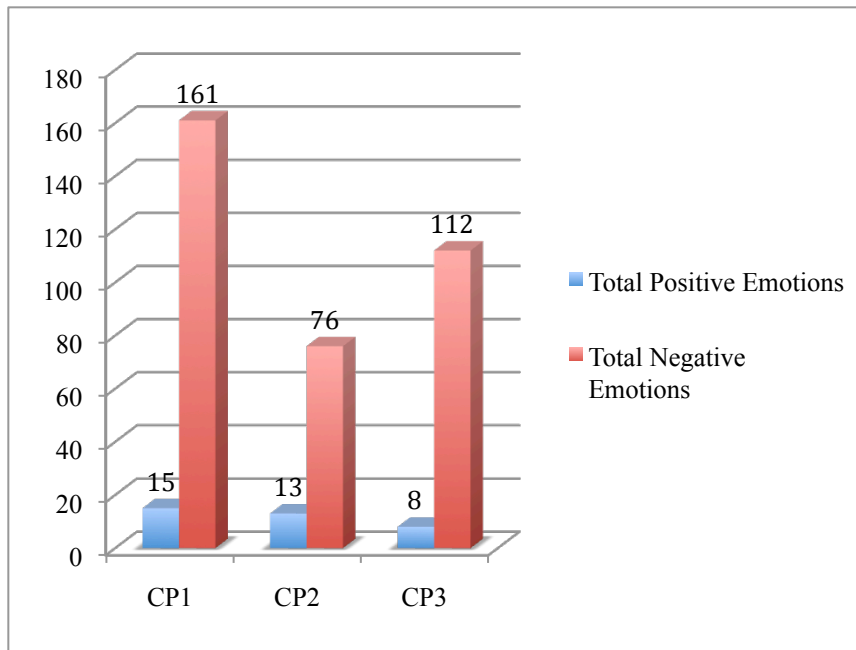


Figure 4. Total positive and negative emotion codes across client-participants

Interestingly, when viewed across the three transcribed sessions, negative emotions typically peaked in the second coded session or decreased in the third session. For example, CP1's negative emotions (including both inferred and expressed) totaled 54 in session #0, 61 in session #1, and 46 in session #2. Similarly, CP2's negative emotions count for sessions #1 and #8 totaled 35, and 6 in session #16. Also, in CP3's session #1, 32 negative emotions were coded, 65 in session #51, and 15 in session #110.

In contrast, no consistent patterns were observed across CP sessions related to positive emotions. CP1's sessions revealed a decrease in positive emotions over time: there were 11 positive emotions coded in session #0, 4 in session #1, and 0 in session #2. On the other hand, CP2's positive emotions in therapy increased incrementally over time (session #1, $n = 1$; session #2, $n = 3$; session #3, $n = 9$). Lastly, a slight midpoint session decrease was noted for CP3's positive emotions: they were coded only for sessions #1 ($n = 4$) and #110 ($n = 4$), as there were no positive emotions coded in session #51.

Section 3: Within-Participant Findings

This section presents Middle Eastern American CP session content material, followed by emotion code and parent themes data, for each of the client-participants in each of his/her three transcribed sessions. Specifically, notable cultural dynamics are included, as well as client-therapist processes such as therapist self-disclosure, interventions, and missed opportunities to assess or reflect on client emotions may have affected or altered the course of treatment.

Client – Participant 1 Session Content

Client-participant 1, session #0. As previously mentioned, the first coded session for CP1 was the intake session. In this session, CP1 discussed his difficulties coping with emotion, his tendency to keep his emotions private, his views and opinions of his “Iranian culture,” as well as family dynamics and the “shame” and embarrassment he experienced when he received a DUI. Examples of each of these emotionally relevant dynamics are presented next along with therapist-client interactional/relationship issues.

First, in the following example, CP1 revealed difficulty with coping with his emotions, and also highlighted his preference to cope with his own issues and to keep his emotions private.

C84: ...But I’ve learned to cope with my own issues and try to deal with it. Keep the relationship private...unless you have a certain question about a situation that you want feedback on.

Relatedly, shame was a salient emotion for CP1 ($n = 15$). CP1 endorsed feeling shame about his partner’s behaviors as a reflection of him:

C110: I feel ashamed...like why does she do that? I don’t know. Cause she’s got a lot to give but she doesn’t feel her self worth. Um it bothers me because, one I’m a respected person. Two, you’re a reflection on me too. Like I don’t want people whispering behind my back...Even if it doesn’t work out with me, I would always tell her, who do you think wants to marry something like this, what kind of image [stutters] what kind of impression are you leaving on people? She knows the severity of it.....

He also appeared to experience shame in light of how he perceived his own actions to bring shame upon his family:

- C147: Worst because - the worst feeling to go to your dad and say, "Hey I got a DUI." And at that time all I cared about was partying. Three to four times a week. Sleep late wake up, do the same routine. Go play basketball with the guys. So it was the worst feeling to go through that. For your family to be ashamed of you. To go through that embarrassment and not be able to pay for it. And it was the best thing to happen to me to realize you know what this isn't the best life for you. To push everyone away, take the right track and just focus now. You've had enough fun.
- T148: So at that point you were 21 or something.
- C148: I just turned 21, two or three months prior. It was painful. Very painful. Shameful... So, was just embarrassing to have to put on an orange jumpsuit to clean up the freeway or whatever. It's like what am I doing? These people are all druggies. And whatever. It's just, bad experience but you know it will never leave me, I'll never drink like that again or put myself in that situation to hurt myself. And go through that failure. But it did mold me as a man. I took things too lightly. Took things for granted. You always got your parents support so you don't care, you think your invisible at one point. You don't think it matters. So it was a good reality slap across the face.

As the session progressed, the therapist asked questions pertaining to the client's cultural identity, and ultimately revealed that she, too, was of Iranian/Persian descent. The following exchange reveals the therapist's self-disclosure:

- T117: ...So you mentioned a few things about going to parties and stuff and how people view you, and image and things, and I'm wondering if that has to do with your culture.
- T118: Yeah. You are Iranian Armenian?
- C118: No! [laughs] Iranian.
- T119: Okay, me too. [smiles]. Yeah, I understand. [laughs]
- C119: You're Persian?
- T120: Yeah. [smiles]
- C120: Oh, I would never have guessed.
- T121: Yeah. Nobody..I..I...
- C121: You're full on Persian?
- T122: Yeah.
- C122: That's awesome.
- T123: Yeah. So I usually, I mean I don't usually tell people but like I just want you to know that I...
- C123: You get it! [smiles]

- T124: I get it! And also you gotta understand that is a stressor in your life because you're in a community and you're worried about all these things American... "American" [gestures quotations with hands]
- T125: American people around you around you don't
- C125: They don't understand!
- T126: Not worried about, don't understand, it is an additional stressor and it's legitimate and it's totally valid and it's something we can talk about and work on and whatever.
- C126: Sweet!
- T127: Yeah [laughs]
- C127: [Client laughs]

The therapist described that she decided to self-disclose to let the client know that she understands his culture, in hopes that it would help him feel comfortable and known.

In consideration of client's previously disclosed preference to keep his inner world private, however, it could also be hypothesized that the therapist's self-disclosure may have negatively affected the course of treatment (e.g., client's ability to freely disclose information). In this session, not long after this talk-turn, CP1 further described his personal views of his Iranian culture, distancing himself from it and reinforcing his stance toward privacy:

- T131: How much do you identify with being Iranian and stuff?
- C131: You know, I'm proud of who I am but the people, the Iranians for the most part in the Los Angeles area are not people I like to identify myself with because a lot of them are materialistic and shallow and a lot of them come from money. They've been pampered a certain way and I'm sure you've seen it too. I don't know I just don't like it. I don't like the way they carry themselves because they're a bit more well off than another person. To act a certain way, a little more humble. I don't come from a lot of money but I appreciate what I have, and I don't think I'm better than anybody. Personally, I may feel my self worth could be worth a little more than someone else only because I carry myself. I keep my comments to myself in closed doors. And I don't judge anyone. Of course we all make judgments about others in passing. But I don't share it. I keep it to myself. And I choose who I want to be in my circle. So. Which coincidentally the older you get gets smaller. That's just reality.

As the session progressed, CP1 continued to share how he preferred to keep his inner beliefs and judgments private, a theme that was salient for CP1 across the rest of the coded sessions.

Client-participant 1, session #1. In the session following intake, CP1 continued to discuss the views he had of his Iranian culture and how cultural dynamics caused him to feel “pressured.” The following example is an illustration of his cultural views and the cultural pressure he described facing to be successful:

- C63: The breadwinner is generally the guy. I mean in our culture the guy has to work and these days women are working a little bit more. But most women that are brought up in that culture are generally conditioned to marry someone of social status and financial well-being. So, that puts a lot of pressure to make you, to, to, I mean, my dad is very humble. He doesn't care. He just wants me to be happy. But my mom, puts this pressure, in her social gathering, “you have to do this, you have to do that,” not that I really care what she says, but that does happen -
- T64: [interrupts client] What do you mean when she says you have to do this?
- C64: Well, she's a mom, she's like why don't you be an attorney or a doctor, typical nonsense...
- T65: [interrupts client] Oh, like in front of her friends...
- C65: Her circle. Yeah. Yeah, it's like dude I don't really care about that. But it puts a little bit of pressure on you. You know, I'm happy with what I do. She doesn't understand it. But, point being, is you know all these people have daughters, this and that, like, it puts that pressure like what can you bring – what can you provide to this person, like, and I don't...really accept it cause they're just looking for financial comfort versus I mean I can offer more than just that. So, it just puts a lot of pressure all around you to to be successful and living here is very expensive, and making sure to put your kids through school and you can retire comfortably and travel and not live paycheck to paycheck. It's really stressful.

One of CP1's most frequently expressed emotions was “stressed,” and often was verbalized when discussing familial and cultural expectations to be successful (e.g., generate high income, become a professional).

Further, towards the end of session #1, CP1 and therapist engaged in what the researchers perceived to be flirtation. The following exchange reveals this dynamic, which the researchers reflected on as inappropriate for client and therapist:

- T162: Okay. Wow we talked about a lot today. I think we're about to wrap up soon. Is there anything else you want to add?
- C162: [shakes head]
- T163: No? We're good?
- C163: Do you?

T164: [shakes head] I'm still getting to know you.
 C164: I feel like it's our first date. [laughs]
 T165: [laughs] Yes but you don't know anything about me
 C165: No, you don't talk much. [laughs]
 T166: That's my job [laughs] Um, ok so just like a housekeeping issue. I turned in the abatement form for your fee and the fee that they gave you was \$25.
 C166: Okay.
 T167: More manageable than \$45
 C167: Sweet.
 T168: Okay, I think we're done for today.
 C168: 'Til the next date huh?
 T169: 'Til our next date.
 C169: How exciting.
 T170: Same time, same place.
 C170: I feel like we're having an affair.
 T171: We're not! [smiles]
 C171: I'm kidding.
 T172: Okay.

In the excerpt presented above, CP1 appeared to push boundaries on what is generally considered ethically inappropriate behavior for psychotherapy, and the therapist appeared to have difficulty holding them. The researchers wondered whether the client, now engaged in flirtatious banter with therapist, may have regarded this exchange as acceptable for therapy and potentially prevented him from further self-disclosure and exploration of affect.

Client-participant 1, session #2. In this session, which was CP1's last session prior to termination, the therapist appeared to significantly challenge CP1. The researchers wondered if this change of stance was in response to the boundary violations at the end of the previous session. In some instances, CP1 appeared to shut down, possibly due to therapist's challenges and over-interpretations. One such example is provided below:

T16: Um like when you were a kid you felt like she kind of just left you and wasn't really there as much as you wanted. Something she also senses in yourself and that she brought it up a later time and asked "Do you hate me?" Of course you don't hate her she's your mom your love her. But you're angry at her.
 C16: Maybe
 T17: I don't know. It's kind of like you have this guilty feeling for being angry.
 C17: [Client nods his head]

- T18: Remember we talked about “she’s my mom I want to treat her well, I want to respect her, and she does all of this for me.”
- C18: Mm-hmm
- T19: How do you feel about just allowing yourself to be angry? Is that even an option?
- C19: To allow myself to be angry? I wouldn’t want that if that. If that were to be the case. Why would I want to be angry at her? What’s been done is done. It’s in the past. I’m grown up so-
- T20: Yeah but it’s still coming up; it’s still hurting you. You feel like you can’t even talk to her.

In another example of how the therapist challenged CP1, here he appeared to engage in silence, possibly avoiding expression of affect or feeling.

- T36: But the thing is that I see is that you’re in distress. The guilt that you’re feeling for the anger, you know what I’m saying? Even if we took the hypothetical Mom out of it. Okay. How would you feel to admit to [CP1’s name] that you have anger and resentment?
- C36: (5 second silence) I don’t know.
- T37: Do you?
- C37: I don’t know if I have anger. I’m really not an angry person. I really just kind of ignore stuff. Resentment probably. But I don’t know, we’ve been that way for some many years I don’t know where it developed. I really don’t know.

In this example, CP1 appeared to become defensive by denying the therapist’s assertions that he was angry and resentful. Similarly, the client shut down when the therapist used an irreverent approach with CP1:

- T46: Yeah everybody has some time issues.
- C46: So I don’t really feel anything about it.
- T47: You don’t feel anything?
- C47: (7 second silence) [client laughs]
- T48: Do you expect me to say something? We’re here for you.
- C48: I don’t know what to say.
- T49: What’s going on?
- C49: If I knew, we wouldn’t be sitting here.

As session progressed, client appeared to continue to demonstrate difficulty with affective expression and self-exploration. Towards the end of session, CP1 and therapist engaged in heated discussion about the content of the session:

- T191: Good, well I think we're about to wrap up – oh I think we have a few more minutes. Is there anything else you want to go over with today? Anything else I need to know?
- C191: Go over?
- T192: Yeah.
- C192: What did we start with? [laughs]
- T193: What did we start with? Well first we were talking about your mom and kinda feelings you have towards her. And then we discussed, um, your girlfriend, and your relationship and your differences in communicating stuff and then a host of games that the two of you play [laughs]
- C193: You think they're games?
- T194: It sounds- it sounds like games. He calls, she calls, she did this because of that and he did this because of that. I'm really curious why you two – I mean its like you have a problem with her you tell her you have a problem, right? And if she has a problem with you obviously she's telling you she has a problem. But it's like why aren't you honest before the problem comes up? Or if you are honest, why doesn't the other person accept it? Like if you were to tell her I kinda wanna just spend time with my guy friends. Honest. Doesn't expect it.

The example above highlights how the therapist, rather than engaging in exploration of affect, provided judgmental commentary about how client interacted with his partner. This may have been influenced by the therapist's own countertransference; nonetheless, it likely affected treatment outcomes as the client terminated treatment following this session.

CP1 Emotion Codes and Parent Theme Integration

CP1's most frequently coded emotion across all three sessions was *Anger*. The *Anger* code was inferred ($n = 54$) much more frequently than expressed ($n = 25$) across all three sessions. The following example from session #0 illustrates how anger was coded as an inferred emotion by the researchers:

- C113: She knows. There were a couple times we were going to break up because I got frustrated. And my eruptions came over the last, over the last course of the past month because I was getting fed up really. I think mentally I just gave up so I was just waiting for her to just do something to erupt and just walk away. But she wouldn't allow it. So...

In this example, CP1 described a past instance of feeling frustrated, further detailing his frustration as “eruptions,” which was interpreted by the researchers as CP1 experiencing past *Anger*.

Similarly, the following example revealed how CP1 verbally expressed anger in session #2:

C77: So things like that really get under my skin. They really irritate me. I had a really long day. Don’t talk that way.

The researchers coded and categorized “irritate” as *Anger*, as defined in the Emotions Definitions Table (see Appendix H). Here, it is important to note that while CP1 was expressing feeling typically irritated under the circumstances he described, he was not labeling affect in the present moment (e.g., “I feel irritated), which constituted, per the Emotion Regulation definition (see Appendix I), a regulatory tactic.

Talk-turns where CP1 expressed an emotion but did not label the emotion as experienced in the moment were frequently noted during coding. The following example from session #0 illustrates *Anger* coded as inferred, and also revealed how CP1 distanced himself from such emotions by referencing himself in the second person.

C103: Yeah. And nothing really bothers you because you don’t care about anything. Nothing gets to you. When you’re in a relationship there’s an emotional attachment. So that thing bothers you, it...it kinda amplifies inside you. Especially me. And it just kinda erupts. [motions with hand from heart] Um...

The aforementioned examples revealed how CP1 used language to indicate experience of *Anger*. At times, CP1 also demonstrated an ability to express emotion and label this emotion in-the-moment, which was also coded under *Emotion Regulation*. *Fear* ($n = 35$), *Stress* ($n = 17$), and *Shame* ($n = 15$) were also frequently coded across CP1’s three sessions. Still, for all emotion codes, inferred codes were coded at a higher frequency than expressed emotion codes. Positive

emotions coded included *Happy* ($n = 9$), *Love* ($n = 4$), and *Pride* ($n = 2$). *Surprise* was coded three times.

At times, positive and negative emotions were coded in the same talk turn. Two examples from sessions #0 and #1, respectively, are provided below.

C110: I feel ashamed...like why does she do that? I don't know...

C131: You know, I'm proud of who I am, but the people, the Iranians for the most part in the Los Angeles area are not people I like to identify myself with because a lot of them are materialistic and shallow and a lot of them come from money...

The examples above highlight specific emotions expressed in the moment (*Shame* and *Pride*), as well as important cultural dynamics, which are later discussed in Section 3: Within-Participant Findings.

Client-Participant 2 Session Content

Client-participant 2, session #1. In the session following intake, CP2 discussed feeling ashamed to state that she was Persian during her formative years. As previously described, CP2's mother was of Romanian descent and her father was of Persian descent.

C74: Growing up there was a certain shame with the Persian side. I don't know if it came more so from my sister or from my friends. But there was ridicule for being Persian.

T75: You were ashamed of being Persian?

C75: Mm-hmm

T76: Can you tell me more about that?

C76: I think a lot of it came from my mom actually she didn't like my dad's parents and I think my dad's family gave her a certain impression of what being Persian is. So she would criticize it a lot to us growing up. It's actually funny because lately I have become a lot closer to my cousins on my dad's side than I am to my cousins on my mom's side. There's a certain- we're becoming more in tuned with that not necessarily the culture because a lot of my cousins are half Persian. But sort of...

T77: More like family bonding?

C77: Yeah, it's like it's on the Persian side it's different but it's really nice. We get along really well. But yeah we used to not even tell people.

T78: That you were Persian?

C78: Mm-hmm

- T79: And you said it was because your mom didn't like your dad's parents.
C79: Yeah my mom used to speak really low of them.
T80: Why is that? Do you know?

The example above also highlighted a missed opportunity by the therapist to engage in affect exploration with CP2. Instead, the therapist seemed concerned with the reasons as to why CP2's mother spoke "low" about CP2's paternal grandparents.

- T86: So when you were growing up how was it to hear your mom talk about this culture that is essentially half of you?
C86: Yeah [Client nods her head] it was- it made me feel ashamed. It made it hard for me to respect my dad. (2 second silence) It was kind of confusing you know. (3 second silence) It made it hard for us to accept our family.
T87: So when you were growing how did that play out with your friends?
C87: It's actually funny because one of my best friends was Persian. Like somehow I got her to get on the bandwagon with me about her own culture. It's so ridiculous. And that was one of my friends that my mom would give me hard time for being friends with.

In contrast to the previous example, here the therapist was able to probe CP2 to explore the emotional impact of her mother's ridicule of her Persian culture. This example also revealed CP2's ability to explore her previous feelings of shame and confusion.

Client-participant 2, session #8. During session #8, which represented the middle point of treatment, CP2 described feeling stressed about her upcoming wedding. During this session she endorsed symptoms consistent with a Major Depressive Disorder (e.g., anhedonia, hopelessness, hypersomnia, low energy, increased appetite, increased sadness, and difficulty concentrating). The therapist seemed to be focused on assessing for Major Depressive Disorder, focusing on her symptoms, timeline, and even assessing for past history of Mania. To the researchers, the therapist did not appear to reflect emotions or demonstrate a collaborative effort to address her symptoms. The example below highlights the therapist's directives, and also illustrates how the therapist likely overwhelmed an already depressed CP2 by asking multiple questions in one talk-turn:

- T119: Right, so we have five minutes left and I think it's really important to think about you going there next week.
- C119: Mm-hmm
- T120: I'm not going to be able to see you. Is your mom going to be there too?
- C120: Mm-hmm [Client bites her lips]
- T121: You already feel all this pressure because of [mother in law] and your mom. What options do you have? What are you going to do once you get there? There might be some tension between everybody. What's it going to be like for you?
- C121: Mm-hmm
- T122: We kind of already talked about that you can take control of it or they can handle it themselves. So kind of just thinking about what's the best option for you. And you know them best. Kind of making it less stressful for you.

Here, the therapist interrupted CP2 to inform her that session was about to end, and then provided her own opinion as to what would be helpful for CP2, rather than collaborate with CP2 and engage her in a discussion into what she believed would be most helpful to prepare for her upcoming photography appointment.

Client-participant 2, session #16. In this session, researchers perceived the client to be attempting to signal termination of treatment, although she seemingly was unable to engage in direct expression of this desire. The data presented below supports the researchers' hypotheses regarding this dynamic.

CP2's last session began by CP2 asking to end session early due to time limits on parking.

- C1: I actually might need to cut this session a little short because of parking.
- T2: Okay that's fine.
- C2: Like probably end at like 40 after if that's okay.
- T3: Yeah that's fine. So how are you?

Next, the session was characterized by a chatty nature between therapist and CP2 about CP2's pregnancy. The therapist questioned CP2's excitement after learning about her pregnancy, despite CP2 explicitly stating she was excited:

- C10: So I went to the doctor this morning just kind of- I'm excited.
- T11: You're excited?

C11: Yeah I'm excited.

T12: You look excited. Like a big smile.

While the therapist was likely engaged in well-meaning dialogue, she did not appear to use interventions directed at exploring affect during this session. Rather, the therapist repeated CP2's words, which did not appear to have a therapeutic effect on CP2:

C36: Yeah he's been great. We're in a really good space right now. We're very happy and very open with each other. Totally on the same page with everything.

T37: Good

C37: It really helped that we had two weeks to hangout and be together and not really worry about anyone else.

T38: How was the flirting and the intimacy?

C38: It was great.

T39: It was great

C39: It was great, yeah. There was no issue with it on our honeymoon. [client laughs]

During this session, CP2 revealed several times that she did not have much to discuss. She also appeared to demonstrate an increased ability to engage in affect exploration, as illustrated below:

C23: I don't think there's that much on my mind this week. Well besides the whole pregnancy thing.

T44: How are you feeling about that? I know you said you were surprised, tell me more about what that was like for you?

C44: I was scared and surprised in the beginning. Um sort of shocked, both of us.

T45: Were you guys trying or not trying?

C45: We weren't trying [client laughs]. It was sort of like we had a couple of times during the wedding we were like "Well let's just not prevent and see what happens."

The therapist also asked questions about CP2's vision as she embarked on this new phase of life, as demonstrated below:

T52: So thinking ahead how do you see yourself as a mom? What's it like to envision yourself as a mom?

C52: Um I don't know, I mean I think it seems natural for me.

T53: Yeah

C53: I just hope the baby is going to be healthy and okay. Regardless I think I'll be good. I can take it on. I see it.

T54: Yeah, what do you see when you think in your head. Do you see a picture?

- C54: Yeah I can see me being with the baby, being a mother. It's always been something that's felt very natural for me. So I don't know
- T55: Have you told your family?
- C55: Yeah, they're all very excited. Very happy. [client smiles and laughs]
- T56: What was that like for you to tell them, to tell your mom?
- C56: It was great, I couldn't wait to tell them. The first thing was that I called them and I told them. They're thrilled, everybody. It's nice, it's a nice feeling. I feel like it's one thing after another I keep surprising them with things.
- T57: Yeah
- C57: Well not surprising but all these exciting things keep happening. It's nice.
- T58: That's good. What else?
- C58: I don't know I feel like things are kind of in place. Everything is good.

Important to note in the example above is how CP2 appeared to be distancing from the therapeutic process, by replying to the therapist that, "Everything is good." Ultimately, CP2 decided to end session early, citing that she needed to return to work, which was a different reason than she what initially stated at the outset of session:

- T83: We have about ten minutes until your parking meter goes buy so I'm going to leave it open to you.
- C83: Okay um I don't know. I don't really have anything on my mind. Would it be okay if we ended the session early?
- T84: If that's what you want to do?
- C84: The only reason is I feel like I probably should get back to work because I had to miss the morning for my doctor's appointment this morning. So I'm wondering if I should cut the session short.
- T85: That's fine. Do you want to tack on an extra ten minutes next time and do a full hour?
- C85: Okay yeah that would be great.
- T86: Alright
- C86: Yeah if we feel like we need it.
- T87: Yeah sure sure.
- C87: Yeah I feel like I also have it in the back of my mind that I'm missing a lot of work today and that I should probably get back.
- T88: Yeah no worries of course.
- C88: Thank you.

This was CP2's last session before terminating treatment. In the example above, it can be hypothesized that CP2 was avoiding directly confronting the therapist in person that she no

longer wanted to continue pursuing treatment. This was ultimately not coded as *Experiential Avoidance*, as CP2 did not explicitly state that she was actively avoiding termination.

CP2 Emotion Codes and Parent Theme Integration

For CP2, *Anger* ($n = 24$) was the most frequently coded emotion across the three psychotherapy sessions, followed by *Sadness* ($n = 15$), *Stress* ($n = 14$), *Fear* ($n = 13$), and *Happy* ($n = 13$). *Surprise* was coded twice.

Similar to CP1, inferred emotion was coded at a higher frequency than expressed emotion. Below is an example from session #8 of *Sadness* inferred and coded by the researchers.

C20: Last night I started crying and had a long talk with him. It was really an emotional talk. We we're talking about how I've been feeling down lately and how a lot of it seems to be related to the wedding. And the fact that we're having this big wedding right now and I feel kind of isolated and guarded. I don't really feel like there's anybody I can talk to or connect to and to be excited about the wedding. [Fiancé] was saying, "I wish we could postpone it," and I felt bad. I wish I didn't feel this way. I wish this were something I could fix.

In this example, while CP2 did not explicitly express a specific emotion, she detailed specific experiences in this talk turn, such as "crying," "feeling down," "isolated," "guarded," "felt bad" that conveyed to the researchers that CP2 experienced *Sadness*. These emotions appeared to parallel symptoms of depression, which comport with CP2's diagnosis of Depressive Disorder NOS. Further analysis of the data revealed how in the first half of session #8 CP2 endorsed feelings of sadness. As session progressed, towards the midway point, CP2 began to endorse feelings of anger related to her mother.

Below, in another example, CP2 expressed feeling "shame" in session #1, although this identification of emotion was not identified as a regulatory tactic, as CP2 did not identify *Shame* as a current emotion. Further, CP2's experience of shame was connected to her earlier negative beliefs about her Persian culture, which were reportedly influenced by her mother. This is a large

contrast to CP1's and CP3's experiences of shame, as these participants did not appear to experience shame specifically about their cultures.

C74: Growing up there was a certain shame with the Persian side. I don't know if it came more so from my sister or from my friends. But there was ridicule for being Persian.

Other expressed emotions were shown in past tense, as illustrated below from session #1.

C60: Nothing horrible. I'm not really sure what- like I don't know if there was something I could have done with my mom when she called that night. Those type of incidents repeated throughout the trip that's what I used to deal with a lot. I was at a loss, I was mad at her. And I was just like, how do I deal with this?

Interestingly, CP2 labeled her affect in the moment on only two occasions across all three psychotherapy sessions, and both examples were illustrated in the Emotion Regulation parent theme section. This type of emotion was coded as *Happy* ($n = 13$).

Further, with respect to *Emotion Dysregulation* parent theme, it should be noted that CP2 evidenced an even use of all three sub-categories. That is, CP2 appeared to demonstrate a proportionate use of *Experiential Avoidance*, *Negative Emotional Reactivity*, and *Difficulty Labeling Current Affect* relative to CP1 and CP3.

Client-Participant 3 Session Content

Client-participant 3, session #1. For CP3, the session following intake was characterized by information gathering, including explanation of his expulsion from a clinical psychology program, as well as a discussion of his cultural identity. As part of this latter discussion, CP3 described not "fitting in" with any specific culture:

C18: Because my father doesn't speak Farsi. English was always- But you know my mom would speak to me in both languages. That's why I can kind of understand. If someone were to speak to me in Farsi I wouldn't really understand each word but I would get a gist of what they were saying.

T19: Remind me again your mom is Persian and your dad is?

C19: My dad is from Israel so he is Israeli but his parents were born in Europe. His parents moved to Israel before it actually became a state. And my father was born

before they had the War of Independence. So yeah I guess he is Israeli but he has like blue eyes. Even though my mom is Persian she's like light Persian. Her family looks more Persian than she does. [Client laughs] But that's the reason why- when I would go around my mom's family I would always be called "Sepid." That means white guy or the color white.

T20: Okay

C20: Yeah and when I would hang around my dad's parents they would look at me kind of like a Middle Eastern guy. That's been my whole life never fitting in one category. Which is cool, I don't have a problem with it. But it's just always been that way. But there are times that I feel my culture, my cultural sophistication has been stunted by that because I don't fit in one area.

T21: Mm-hmm

C21: Even though I'm cool with it now, I'm not sitting here everyday going like oh my God my culture. I'm not like that but 100% I wonder what it be like to have people the same as me because I don't have that. I don't have that at all. It would be very interesting.

T22: Right, it sounds like based on your childhood experiences you haven't fit into one side or the other?

C22: Absolutely not no. [Client shakes his head]

In the exchange above, CP3 described his physical characteristics, which he perceived to be in contrast to what he considered typically Middle Eastern, and noted how his mother's family would label him as "white." This example also illustrated how, while he initially described feeling as though he did not fit in, he appeared to demonstrate some degree of acceptance (e.g., "I'm cool with it now").

Client-participant 3, session #51. This session represented approximately the mid-point of therapy for CP3. In this session, it became clear that the therapist likely disclosed her cultural background to CP3 in a previous session, as CP3 attempted to relate to the therapist by comparing similarities between cultures. The following talk-turn also revealed the pressures CP3 faced, which were apparently rooted in cultural norms:

T40: So you've mentioned not being in a relationship, not feeling like you don't have a career feeling like the research and everything you worked on at school doesn't count so at least you can identify the things that you feel like can give you a sense of purpose, right?

C40: Yeah. Yeah. Because from this from this culture that I...half the culture on my mom's side of the family which is probably similar to your culture in certain

ways, um, success is defined by family, defined by hard work, defined by career, you know what I mean? Defined by – and then when you're comfortable in life you help your parents out if needed. That's what success is defined by. I don't have any of those and I'm not working towards it, you know?

Further discussion of how CP3 engaged in social comparisons revealed how he connected the pressure he felt to be successful with cultural expectations:

- T56: I wonder who or what is putting that like sense of time limit and pressure on you.
C56: Me.
T57: You are?
C57: Well cause I have always had this im-image or this ideal, right. 40 years old should have couple kids by now, should be married, have a couple dollars saved up I was able to save a few couple thousand dollars this year, past year. i think like six. What's that worth, that's embarrassing. I can't tell anyone that. I have relatives, they make twice as much in a week or in a few days. So who are my relatives that I see? "How's everything going?" "I'm pretty excited, I saved 6,000 in 2014" "Oh yeah? I made 6,000 in the past couple days' It's tough! It's fucking tough!" [laughs]
T58: So this goes back to the comparisons, and the perceptions...
C58: It's the cultural thing [shakes head]
T59: Right it – it is the cultural thing. I'm gonna agree with you there cause like you said there are similar values that both of our cultures hold right. And within that try to function as an individual of a particular culture that has certain values. Um, but I wonder is that a value that you hold personally?
C59: It's very easy f-for-for me to say that money doesn't make who you are. Because I don't have any. [laughs]
T60: Mhm. Right
C60: So it's - it's very easy to say this person doesn't have money, they're - they're so down to earth right. Or the other way around. This person is so down to earth, they don't have money. That's why. They're so down to earth. It's so easy to say that. Okay. and its hard to say you know what if I had money I probably wouldn't be down to earth cause I probably would be less down to earth if I had money – or maybe not because I've lived my life com-compared to people in my family and people in my - my mom's culture let's say I've always been the one that didn't have money. You know what I mean? So I don't think I could lose being down to earth. I've been like that my entire life. That being said when I have to socialize at these events, socializing is a pain in the ass as is, anxiety wise, stuttering wise, and money wise.

In this session, CP3 also utilized humor frequently to manage discomfort, also illustrated in the example above (C59). CP3 often moved away from exploration of affect with the therapist by utilizing laughter and humor after he described himself to be failing, as illustrated below:

- T46: Okay. So what would that look like for you then? Like how would you conceptualize that for yourself?
- C46: [laughs] I have no idea. I don't know why I'm laughing. That made me laugh for some reason.
- T47: Why did that make you laugh, [client's name]?
- C47: I don't know. Cause in a way this – this is all big joke to me. This is my cranky side right now [laughs] this is my irritable -
- T48: That's okay.
- C48: Like I don't mean here with you in this building. I mean in general. Everything is a big friggin' joke right now. I feel like the joke is on me. I feel like I'm failing. You know if you play a video game you get the game over sign a lot, I feel like it's constantly game over game over.
- T49: Well I mean it's understandable to feel that way though, right?
- C49: I'm losing. I am not winning. Remember Charlie Sheen when he went nuts? Winning? Right that's not me. I'm the opposite. Maybe I should go viral on YouTube and "losing" that would be good [smiles]
- T50: Well I hardly think it's a good idea to compare yourself to Charlie Sheen [laughs]
- C50: I'm not. I'm not comparing myself. It's the opposite of Charlie Sheen [yawns and rubs arm].

While the therapist validated CP-3's experience, this example also represented a missed opportunity by the therapist to directly inquire about client's affect in the moment.

In another example, the client asked for direct advice or recommendations as to how to proceed with a more intense exploration of content and/or affect in sessions. Below is an example of this request by CP3:

- C120: Do you ever feel like I run in circles that I don't get deep enough or...
- T121: I wouldn't say that. No, I wouldn't say that at all.
- C121: Okay. Well, you don't have any recommendations for me and how I should be here to move forward or?
- T122: Recommendations you mean in terms of treatment or...
- C122: Um. Oh I do want to mention what you talked about last week. No, in terms of getting more and more deep.

Here, CP3 appeared to demonstrate the ability to reflect on his experience in treatment, and was possibly experiencing insecurity about his ability and capacity to fully interact in his emotional experience, or as he termed it, "getting more and more deep."

Client-participant 3, session #110. During Session #110, which represented the tail end of CP3's treatment, the session was characterized by CP3 endorsing improved mood and anxiety. However, CP3 evidenced interpersonal insecurities within the client-therapist working alliance throughout this session.

- C17: I'm waking up early again like I used to. So the past two days I woke up early and got some work done.
T18: Mm-hmm
C18: No bad anxiety since the last week. Nothing great but not bad anxiety. I smoked uh twice since last week and I sprayed once so that's three [client laughs] before I went to sleep. Um that's about it.
T19: Okay
C19: You can write that down don't worry.
T20: No it's fine.
C20: "He is half way to drug abuse." [client laughs]

Client used humor and laughter likely to manage discomfort with how he might be perceived by the therapist. In another example client appeared insecure about the content of his verbal expressions:

- C25: That's it, it's not the end of the world either way.
T26: Okay
C26: [client laughs]
T27: What's so funny?
C27: I don't know. It's just a split second I put myself as an observer here and I was just laughing
T28: What was that observer thing?
C28: Some random guy just talking some meaningless shit [client laughs] about his life. I know it's not meaningless to you. It's more meaningless to me than it is to you. Because this is your job not that this doesn't have meaning because it has meaning. But um I'm just spewing random stuff.
T29: I think you always had that kind of sentiment where it's always like this what am I doing, why am I here, this is weird.
C29: It was way worse before, it's not as bad now.
T30: Yeah.
C30: Not at all. I see the value of it. I think everyone would benefit from it from some kind of therapy. They have to have a good therapist though. They really do, that means a lot. Too bad I didn't have one for three years [client laughs] no I'm joking.
T31: [Therapist smiles]
C31: That's a joke by the way.

CP3 also appeared to indirectly state that he perceived his therapist to be “good,” and used humor to distance himself from directly expressing this to therapist. These examples, including the example below, also highlight CP3’s sensitivities to interpersonal dynamics and to his previous performance as an ex-clinical psychology student. Below, CP3 appeared to demonstrate sensitivity to therapist’s nonverbal behaviors:

- T94: Are you thinking of- I guess this is kind of your own self-exploration. Have you given thought about visiting your dad at all?
- C95: He’s been telling me to do that. But I don’t want to go to the Philippines it’s way to far. You know what I mean.
- T95: Mm-hmm
- C96: His number one priority and more power to the guy. He’s in his early 70’s. That’s crazy. His number one priority is his young girlfriends. That’s all he ever wants to talk about. That’s kind of boring after a while. He sent me a couple of videos that I have here. If you want to see what he looks like. That’s not needed?
- T96: It’s up to you.
- C97: But you went like [client shakes his head and shrugs].
- T97: No it’s like up to you.

The example above also revealed a missed opportunity by the therapist to engage CP3 in exploration of feeling. This presented as an opportune moment to explore and understand CP3’s interpersonal difficulties that were relevant to treatment given his diagnosis of Social Anxiety Disorder.

CP3 Emotion Codes and Parent Theme Integration

In contrast to CP1’s and CP2’s transcribed sessions that revealed *Anger* as the most frequently coded emotion, CP3’s most frequent code was *Fear* ($n = 33$). Furthermore, *Fear* and one other highly coded emotion, *Anger* ($n = 25$), were found to be expressed more often than inferred, which was also a different pattern from CP1 and CP2. *Fear* as expressed emotion ($n = 21$) was coded at a higher frequency than inferred ($n = 12$) across all three sessions. Additionally, *Anger* ($n = 25$) codes also revealed a higher frequency for expressed ($n = 16$) than inferred ($n =$

9) emotion. No other coded emotions revealed this pattern; for example, *Shame* ($n = 21$) codes were double in frequency for inferred ($n = 14$) than expressed ($n = 7$) emotion.

Another frequently coded emotion was *Sadness* ($n = 14$), and one such example of inferred *Sadness* emotion from session #1 is illustrated below.

C42: One day after we're done I hear a couple people saying, "So we're going to meet at that place?" And I'm like, how come they didn't ask me? That's fucked up. But then I think I keep everyone at a distance, of course they're not going to ask me. It's not that they don't like me.

In this example above, researchers inferred CP2 experienced feeling rejection and sadness (e.g., "...how come they didn't ask me? That's fucked up."). As such, these inferred emotions were categorized under *Sadness* given the content of the talk-turn. In another example below of expressed emotion, in session #51 CP3 stated, "It's embarrassing," which was subsequently coded as an expressed emotion under the *Shame* category.

C37: ...And people are gonna be talking. What, like, what's my purpose, here? Right. I'm the only single person here. And my mom doesn't count cause she has kids whatever right. I'm the only single guy here. I don't have a career. I don't – I don't have such a – I don't have a career. They're gonna ask me about, "So tell us about your school. You're gonna be done by now right? You're working in a - in a clinical setting? What's going on? Any research you working on?" I'm not gonna tell people what's really going on. It's like when someone says hey how are you? And if you're having a bad day you're gonna be like I'm having a shitty day. They don't want to hear that right. So...what? Do I have to lie? Right? Everything is great yeah. School is almost over. Do I lie? Do I tell people? Like what's my purpose?... I'm 37 years old it's the same situation right. I'm there. I'm living here with my hard-working mom. It's embarrassing. It's the same situation. It's a pride thing you know?

This example also highlights how despite expressing "It's embarrassing," CP3 was not labeling affect in the moment; as such, it was not coded as *Labeling Current Affect* under the Emotion Regulation parent theme. Further, the example above also highlighted a frequently noted theme that occurred across sessions where CP3 reported feeling embarrassed and shameful

about his age, marital and employment status, especially when comparing and contrasting to individuals in his family and broader cultural community he perceived to be successful.

Summary. Various cultural dynamics among the client-participants presented in each transcribed psychotherapy sessions. For example, although *Shame* existed for all CPs, it manifested in different ways depending on context or cultural variables. For instance, CP2 experienced shame for being Persian in her formative years; however, CP1 and CP3 evidenced *Shame* about current perceived moments of embarrassment with family as well as lack of financial success. Client-therapist dynamics, such as use of self-disclosure, specific interventions used to engage emotional expression, and missed opportunities to engage in emotion regulation tactics were apparent across sessions. All CPs' most frequently coded emotions across all three sessions were considered negative (CP1; $n = 161$; CP2; $n = 76$; CP3; $n = 112$), such as *Anger*, *Fear*, and *Shame*, whereas their positive emotions were substantially less frequent (CP1, $n = 15$; CP2, $n = 13$; CP3, $n = 8$), including *Hope*, *Pride*, and *Love*. A primary emotion of *Surprise* that did not fit neatly into the positive or negative category also emerged from the data, albeit infrequently ($n = 5$).

Chapter 5: Discussion

Overview

Middle Eastern Americans are largely underrepresented in the psychotherapy literature, despite evidence to suggest the growing need for mental health services with this population. Much of the current literature on Middle Eastern Americans in psychotherapy highlights authors' views, anecdotes, and opinions on how mental health clinicians should approach individuals of this population in light of acculturative and generational difficulties, war trauma and intergenerational trauma, and other salient cultural factors. This dissertation study redressed the need to examine actual Middle Eastern American clients in psychotherapy.

In a review of the literature, only two studies were located that surveyed therapists working with Arab American clients. These studies gathered therapists' accounts of specific mental health concerns afflicting their Arab American clients: depression, substance abuse, and PTSD (Nassar-McMillan & Hakim-Larson, 2003), and "cultural difficulties; marital problems; school/education related issues; behavior problems or developmental disabilities; and mental disorders such as major depression, bipolar disorder, and schizophrenia" (Nassar-McMillan & Hakim-Larson, 2003, p. 152). The Iranian CPs in the present study evidenced some similar diagnoses (those related to depression, anxiety and relational problems) and researcher-observed issues (cultural difficulties, school/education, anger regulation), but concerns about personal substance abuse, PTSD, developmental disabilities, bipolar disorder and schizophrenia were not found in this small sample. While both Arab Americans and Iranians fall under the Middle Eastern umbrella and share similar cultural norms and values (Gregg, 2005; Rassam, 1995; Sayyedi et al., 2011), within-group differences must be acknowledged. Further investigation is

needed to determine whether the whole range of clinical conditions noted by Nassar-McMillan & Hakim-Larson (2003) applies to Iranian Americans more generally.

Further, salient cultural factors highlighted within the limited literature on Middle Eastern individuals and clients in psychotherapy revealed that emotion is generally understood to be inhibited by this population (Abdi et al., 2012; Al-Krenawi & Graham, 2000; Dwairy, 2009; Haboush, 2005; Jalali, 2005) and that positive emotional regulation has only recently been researched (Ma et al., 2018). The present study contributes to this needed area of inquiry, finding both frequent experiential avoidance of negative emotions as well as positive emotional regulation via acceptance, increasing positive emotional events, and labeling current affect.

The ability to regulate emotions has been connected to psychosocial (Eisenberg, Fabes, Guthrie, & Reiser, 2000) and psychological functioning (Gross & Thompson, 2007; Nyklíček, Vingerhoets, & Zeelenberg, 2011), as well as physical health (Gross & Muñoz, 1995; Sapolsky, 2007). While the study of emotion regulation is well established in the scientific literature, little is known about this construct with the Middle Eastern American population, as no literature to date has focused on how Middle Eastern Americans identify, express, inhibit, or regulate emotions within the context of psychotherapy. Thus, the research questions posed in this study asked how emotions were expressed and regulated by Middle Eastern Americans within the context of psychotherapy. In order to answer these research questions and address this gap in the literature, the researcher utilized inductive content analysis in a naturalistic setting to examine how three self-identified Middle Eastern American client-participants managed and expressed their emotions.

In examining nine psychotherapy sessions, the researcher found consistencies and patterns across and within all three client-participants. Namely two Parent-Themes emerged from

a review of data pertaining to how client-participants managed their emotions (Research Question 2): (a) Emotion Dysregulation, and (b) Emotion Regulation. Correspondingly, a range of 12 categories expressed and inferred positive and negative emotions emerged across all three client-participants (Research Question 1): *Anger, Happy, Pride, Love, Discomfort, Surprise, Fear, Sadness, Shame, Stress, Guilt, and Hopefulness*.

This chapter begins with a discussion of these Parent themes of Emotion Dysregulation and Emotion Regulation placed in the context of the existing literature, accompanied by their sub-themes. Next, emotion codes as well as within-participant findings are discussed in the context of current literature. Limitations of the study are then discussed, followed by a presentation of the contributions of this study and the implications for future research and practice.

General Findings

Much of the literature describing affective expression of emotion among Middle Eastern individuals falls under the *Emotion Dysregulation* Parent Theme. For this reason, it is discussed first.

Parent theme: Emotion dysregulation. The Emotion Dysregulation theme was defined in the current study through its categories as the use of maladaptive regulation strategies, lower emotional awareness, and/or the inability to inhibit or regulate distressing emotions, as evidenced in session or as described by the client, all of which appeared to affect the client-participant by eliciting a negative and/or maladaptive internal or external reaction. This definition comports with specific assessment measures of emotional regulation, namely the DERS, ERQ, and AAQ. As previously mentioned, the DERS was translated for use with Iranians.

Moreover, this study's definition fits with some of the emotional regulation models reviewed earlier that described components of emotion dysregulation: DBT, ACT, the Appraisal Model, and the Extended Process Model of Emotion Regulation. DBT views emotion dysregulation as emotional vulnerability (made up of emotion sensitivity and heightened and labile negative affect) and lack of skills to be aware of (identify and understand emotions) and regulate emotions (made up of a deficit of appropriate emotional expression and regulation strategies, with a surplus of maladaptive regulation strategies; Carpenter & Trull, 2013; Linehan, 1993). Although the current study's definition of Emotion Dysregulation maps on to DBT skills needed to regulate distressing emotions, it does not incorporate emotional vulnerability into its definition. Similarly, ACT holds the position that the experience of unpleasant emotion is the result of distorted cognitive processes that eventually lead to behaviors that are problematic and used to avoid or reduce the unpleasant emotions (Blackledge & Hayes, 2001). The Extended Process Model of Regulation takes into consideration identification of emotions as part of a regulatory process (Gross & John, 2003). Moreover, the Extended Process Model of Regulation views *suppression* as inhibition of emotional experience and/or behaviors (Gross & John, 2003), which aligns with the current study's definition of *Experiential Avoidance*.

Moreover, current literature on communication and affective expression in Middle Eastern cultures suggest that specific cultural norms, such as inhibition of emotion and active concealment of one's own feelings, map on to what current literature defines as emotion dysregulation (Al-Krenawi & Graham, 2000; Dwairy, 2009; Haboush, 2005). This can be understood using the social construction model of emotion (Harré, 1986; Solomon, 2003), as it takes into consideration how sociocultural factors affect the generation of emotion, and how emotion is formed via culturally-specified roles (Gross & Barrett, 2011). Further, according to

appraisal theorists, an individual's appraisal of an event is influenced by a person's culture and can provoke a different emotional response among different individuals (Ellsworth, 2013). In light of what is known on communication and affective expression among Middle Eastern individuals, this model also helps to understand emotion regulation with this population in their cultural context.

As part of that cultural construction process, work is needed to determine the extent to which the strategies coded in the present study are appropriately labeled as dysregulation. Although the researchers observed that these strategies were marked by difficult emotional experiences for the client-participants, it may be premature to label them as maladaptive. Because different cultural groups may or may not view emotion dysregulation as maladaptive and/or a negative construct, an issue of construct validity is raised when examining emotion regulation cross-culturally, and is further discussed in the subsection below on future research.

To further explore the *Emotion Dysregulation* parent theme among the three Middle Eastern American client-participants, its three lower level categories, *Experiential Avoidance* ($n = 82$), *Negative Emotional Reactivity* ($n = 19$), and *Difficulty Labeling Current Affect* ($n = 8$) are next discussed and compared and contrasted to the extant literature's understanding of emotion dysregulation with this population.

Sub-theme: Experiential avoidance. In the present study, *Experiential Avoidance* was coded 82 times across the three participants, the most frequently coded category. Across all three participants, *Experiential Avoidance* was seen as avoidance of interpersonal relational stressors, isolation, avoidance of negative emotional experience, suppression of emotion, as well as avoidance of exploration of affect within sessions. For example:

T19: How do you feel about just allowing yourself to be angry? Is that even an option?

- C19: To allow myself to be angry? I wouldn't want that if that. If that were to be the case. Why would I want to be angry at her? What's been done is done. It's in the past. I'm grown up so-
- T20: Yeah but it's still coming up it's still hurting you. You feel like you can't even talk to her.
- C20: She's just too much, she's too lovey dovey. Maybe part of me feels like it's too late and I just shut off. At the same time I know it hurts her so it's not right to repel against that because it only hurts her so much more.

Thus, this category included both the individual's avoidance of his/her personal experiences as well as the avoidance of discussing personal experiences with others, including the therapist.

As such, the current study's understanding of Experiential Avoidance is similar to the concept of Experiential Avoidance in ACT. In the literature on ACT, this concept involves avoiding thoughts, feelings, inner emotional experiences, physical sensations, and/or memories, and/or engaging in behaviors to avoid these specific situations and contexts (Blackledge & Hayes, 2001). Not only does the ACT definition of experiential avoidance help one understand the cognitive, emotional, and behavioral understanding of avoidance, this theory also provides a holistic understanding of how and why an individual utilizes avoidance, as well as its consequences, which can include an increase in maladaptive behavior (e.g., substance abuse, high-risk sexual activities, avoiding intimacy and relationships; Blackledge & Hayes, 2001). In the present study, some of these cited behaviors were coded (e.g., substance use; $n = 2$), but other ones also emerged (i.e., emotional eating; $n = 7$).

Although such strategies were not found to be heavily common concerns among the Middle Eastern population following a review of the literature, they nonetheless fit the definition of experiential avoidance, per the ACT and DBT models, as the individual attempts to avoid feelings of discomfort by engaging in behaviors that mask his/her emotions (Blackledge & Hayes, 2001; Linehan, 1993).

The Experiential Avoidance findings in this study support the current literature's discussion of emotional inhibition and its assessment in Middle Eastern populations. The ERQ, which measures emotion regulation using two subscales, reappraisal and suppression (Gross & John, 2003), was translated and adapted for use in Arabic-speaking countries to study cross-cultural differences in reappraisal and suppression among participants in four Arabic countries (Egypt, Kingdom of Saudi Arabia, Kuwait, Qatar) and the United States of America (Megreya et al., 2018). Interestingly, participants from the Arabic-speaking countries scored higher on suppression than participants from the USA (Megreya et al., 2018). This finding, in conjunction with this study's findings on *Experiential Avoidance* supports the extant literature's description of emotional expression among Middle Eastern individuals. Specifically, experiential avoidance refers to the individual's difficulty to allow oneself to be in touch with one's private internal emotional experiences; as such, it can be postulated that with such difficulties the individual cannot engage in emotional expression. Furthermore, expressions of conflict or negative feelings to others are not tolerated in Middle Eastern cultures, as emotions are typically concealed (Abdi et al., 2012; Al-Krenawi & Graham, 2000; Dwairy, 2009; Haboush, 2005; Jalali, 2005).

Moreover, Middle Eastern cultural values are typically collectivistic in nature, with emphasis placed on the family unit (Haboush, 2005) and lesser value on the individual's concerns and feelings. As a result, expectations for behavior that are in-line with family and cultural values may be learned over time and represent well-established patterns of behavior. Such expectations (e.g., maintaining privacy within personal and family lives) are expected to be upheld by members of the larger family unit. One example of maintaining privacy was seen in CPI's session #0:

C84: ...But I've learned to cope with my own issues and try to deal with it. Keep the relationship private...unless you have a certain question about a situation that you want feedback on.

Further, according to DBT, individuals with emotion regulation deficits struggle with modulating their emotions, as inhibition, escape, and avoidance have been learned and reinforced over time, effectively increasing their emotional reactivity (Linehan, 1993). As such, Middle Eastern Americans living in the United States, a country in which the broad culture espouses individualism and encourages individual emotional expression, may face difficulties with the intersection of these cultural dynamics. As such, difficulties and conflicts may present in the psychotherapy setting, as bicultural conflicts likely will have implications for treatment in the setting of psychotherapy where emotional expression is typically expected (see Current Status of Research on Middle Eastern Clients in Psychotherapy).

Based on a review of the literature, no research appears to have been conducted specifically examining experiential avoidance and its treatment using DBT, ACT or other approaches with the Middle Eastern American population. Third-wave approaches, such as DBT and ACT, appear to be promising interventions to target experiential avoidance. A meta-analysis of 32 studies ($n = 2,198$) revealed small (Hedges' $g = .38$, 95% CI = .11 - .64) to large (Hedges' $g = 1.32$, 95% CI = .61 - 2.02) effect sizes for the use of mindfulness and acceptance-based techniques with psychotherapy clients from non-dominant ethnic, cultural, or marginalized backgrounds (Fuchs et al., 2013). Also, several controlled trials have demonstrated efficacy with using mindfulness and acceptance-based techniques among Latino and Southeast Asian populations (Hinton, Hofmann, Rivera, Otto, & Pollack, 2011; Hinton et al., 2004, Hinton et al., 2005). Hinton, Pick, Hoffman, & Otto (2013) suggesting that these techniques can be tailored for use with other ethnic minority groups.

In sum, as inhibition and suppression of emotion are culturally ingrained, it was not surprising that they accordingly were frequently observed in the present study. These patterns also fall within the realm of experiential avoidance, as outlined by ACT and DBT, and could be targets for treatment in this population.

Sub-theme: Negative emotional reactivity. This study found *Negative Emotional Reactivity* coded 19 times across all three client-participants. *Negative Emotional Reactivity* was defined for the purposes of this study as heightened adverse emotional response to environmental or internal stimuli. As previously described, emotion dysregulation, as seen in DBT theory, includes the experience of heightened and labile negative affect (Carpenter & Trull, 2013; Linehan, 1993). Moreover, according to DBT, emotional intensity refers to an intense reaction to emotion-provoking situations or stimuli that disrupts cognition and the ability to self-regulate (Linehan, 1993). DBT's understanding and description of heightened, labile negative affect as well as emotion sensitivity provides a clear understanding of how such cognitive and emotional processes lead to emotion dysregulation difficulties (Linehan, 1993).

Gender differences in *Negative Emotional Reactivity* were present, as two male client-participants evidenced heightened negative labile affect that appeared externalized, while the female client-participant evidenced a more internalized negative affect (e.g., crying). While comparatively low to CP1 and CP3, CP2 evidenced higher frequency counts for *Anger* in sessions #1 and #8. However, *Anger* was not coded in her last treatment session. These findings appear to support the literature's explanation of gender-based differences of negative expressions of anger among Middle Eastern individuals. Specifically, within Middle Eastern culture, while exploration of affect is discouraged, male expressions of anger and aggressiveness are tolerated, accepted, and somewhat valued (Haboush, 2005). Although men in Middle Eastern cultures are

encouraged to outwardly convey feelings of anger, women are discouraged from expressing emotions largely due to cultural emphasis and values on the family unit, specifically pertaining to shame and honor (Haboush, 2005).

In accordance with this literature, CP2's sessions revealed several instances of *Negative Emotional Reactivity*: however, her reactions to negatively perceived stimuli were characterized by internalized reactions to her experiences rather than outward displays of anger or frustration.

For instance:

C70: ...I couldn't concentrate on what he was telling me. But at the same time as soon as I heard it was bad news it just threw me over the edge. I started crying like out of frustration. And the night before that I had a decent day and then [fiancé] started talking about something that was negative. And I feel like so vulnerable like if I feel good it's so easy for me to fall back and feel badly again.

In the above example, CP2's tearful reaction to bad news revealed a more internalized negative reaction to an emotionally provoking situation. Interestingly, in a study examining the Farsi translation of the CERQ with a university-student population, females scored higher on catastrophizing than did males (Abdi et al., 2012). Further, in the Arabic translation of the CERQ (CERQ-AR), females scored higher in rumination than their male counterparts, suggesting that rumination is a strong cognitive emotional processing component among Arabic-speaking females (Megreya et al., 2016). This study's findings, in conjunction with the self-report assessment findings, may further support current literature on the inhibition of negative affective expression among Middle Eastern females (Haboush, 2005; Jalali, 2005).

Our qualitative findings also comport with ways that negative affect is captured in self report measures, namely items from the Emotional Expressivity Scale (Kring et al., 1994), the *Berkeley Expressivity Questionnaire* (Gross & John, 1997), and the *Difficulties in Emotion*

Regulation Scale (DERS; Gratz & Roemer, 2004); however, only the DERS has been translated for use with an Iranian clinical sample (akin to the present study).

For example, the DERS measures the following domains: “(a) awareness and understanding of emotions; (b) acceptance of emotions; (c) the ability to engage in goal-directed behavior, and refrain from impulsive behavior, when experiencing negative emotions; and (d) access to emotion regulation strategies perceived as effective” (Gratz & Roemer, 2004, p. 43). The *Negative Emotion Reactivity* code reflects overt difficulty with domain (c), as seen in the following example from CP3’s transcribed therapy session (session #51). It illustrates the degree to which CP3 was aware of his emotions, although he was unable to refrain from impulsively and negatively reacting to his anger. Here, he described an instance of intense angry reaction to an emotion-provoking situation, and was met with compliance from his students, which he perceived as a positive reaction:

C94: When I walk – when I walk into class I just had this angst, this irritability of being there and then as the lecture starts, yeah, last week. Mon-Monday of this week first class I taught this week I went in and I was very irr-irritable and then people were talking and then I just gave it to everybody. It felt good thought. Immediately everybody [sits up puts hands close to self to mimic alertness of students] they were like Oh shit. Maybe that’s a good thing right. [rubs eyes].

In sum, CP1 and CP3’s tendencies to display outward and externalized reactions to negative stimuli, in contrast to CP2’s more internalized reaction, appear to align with literature on the gender differences of affective emotional response among Middle Eastern individuals. As such, gender-based differences, and the understanding of family cultural values among Middle Eastern individuals, should be considered when working with this population, in order to effectively target treatment interventions.

Sub-theme: Difficulty labeling current affect. The *Difficulty Labeling Affect* category was defined as the inability to identify, label, and distinguish emotions. According to the DBT

biosocial theory, and for the purposes of this study, individuals with little or no emotional awareness to identify and label emotions, and to distinguish emotions, can indicate significant emotion regulation difficulties (Crowell, Beachaine, & Linehan, 2009). The DERS (Gratz & Roemer, 2004), the TAS (Bagby et al., 1994) and the TMMS (Salovey et al., 1995) also capture this category in the self-report measures.

Current literature on Middle Eastern individuals does not indicate that this population exhibits difficulty identifying, labeling, and distinguishing emotions. However, it can be hypothesized that because it is widely known in the literature that Middle Eastern individuals typically conceal and inhibit emotion, that difficulties may naturally arise when attempting to distinguish their emotions. More information is needed to confirm this hypothesis, and such data can be helpfully gathered via use of empirical data gathered from assessment measures, as well as from qualitative studies.

In the present study, *Difficulty Labeling Affect* was coded eight times across all nine psychotherapy sessions, and revealed variances across all three participants. The following excerpts highlight examples of how the three participants struggled with labeling and distinguishing affect:

CP1, session # 1

C55: So, I guess I'm emotional right? I'm not emotional! I'm exaggerating. But I get emotionally tied down to things and I won't let it go.

CP2, session # 1

C1: So, I was having some, not concerns but stress about therapy and the same kind of stress that I think I've had in the past. I'm not quite sure, like when I'm in a good space, generally during the day when it's a workday and I'm focused. It's hard for me to extract my emotions and thoughts of what's bothering me or what the issues are otherwise.

CP3, session # 51

C46: [Laughs] I have no idea. I don't know why I'm laughing. That made me laugh for some reason.

Moreover, in the above examples, while the client-participants appeared to demonstrate difficulty with identifying and labeling affect, which mostly occurred in the first and second transcribed sessions, it can be hypothesized that CP1 and CP3 may also be attempting to inhibit negative experiences, otherwise known in this study and in third-wave ACT and DBT models as *Experiential Avoidance*. In CP2's example, the difficulty she faced with differentiating her emotions may likely stem from cultural and familial expectations to inhibit emotions, thereby reducing her ability overtime to learn to identify and distinguish emotions. Note that a discussion of the actual emotions labeled or expressed during the sessions are discussed below in the emotion section.

Parent theme: Emotion regulation. Answering the second research question, this study provided novel evidence that our sample of Iranian American clients in psychotherapy regulated their emotions using positive strategies. In a meta-analytic review of emotion regulation strategies for dealing with a range of psychopathology, positive emotional regulation strategies broadly include acceptance, problem-solving, and reappraisal (Aldao, Nolen-Hoeksema, & Schweizer, 2010).

The current study found the emotion regulatory tactics utilized by the three client-participants represented flexible attempts to positively change the trajectory of experiences or to increase overall positive mood, namely the categories of *Acceptance* ($n = 12$), *Increasing Positive Emotional Events* ($n = 6$), and *Labeling Current Affect* ($n = 17$). This study's finding of emotional regulation strategies is significant because much of the literature describing affective expression of emotion among Middle Eastern individuals falls under the *Emotion Dysregulation* umbrella rather than the emotional regulation domain.

Based on this study's categories, the researchers defined the Emotion Regulation theme as how the client manages his/her emotions by flexibly and adaptively responding to negative emotional experiences. This definition aligns with current literature's definition of emotion regulation across several models. For example, according to Gross, Sheppes, and Urry (2011a), emotion regulation is utilized when attempting to influence an ongoing or future emotion. Specifically, emotion regulation is utilized to increase, maintain, or decrease feelings, behaviors, and/or physiological responses of an emotional response (Eftekhari et al., 2009; Gross, 1999), such as through *cognitive reappraisal* (Gross & John, 2003). Similarly, according to the Instrumental Approach, individuals seek to feel specific emotions in a goal-directed manner based on their cultural values (Ma et al., 2018; Tamir et al., 2016). Additionally, in DBT, emotion dysregulation is targeted in psychotherapy through the use of emotion regulation techniques, which include mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation (Linehan, 2015).

Also, the three categories of *Emotion Regulation* codes found in this study *Acceptance*, *Increasing Positive Emotional Events*, and *Labeling Current Affect*, are understood in the general emotion regulation literature as tactics used to regulate affect. Additionally, *Acceptance* is a category measured in the CERQ, AAQ, and the DERS and *Labeling Current Affect* is measured in the BEQ, TMMS, and the DERS. Notably, however, they are not described as strategies inherently or culturally used by Middle Eastern individuals. A review of the literature on Middle Eastern communication, emotional expression, and presenting issues in treatment (Abdi et al., 2012; Abdulla & Brown, 2011; Al-Krenawi & Graham, 2000; Dwairy & Van Sickle, 1996; Erickson & Al-Timimi, 2001; Haboush, 2005; Jalali, 2005; Sayed, 2003) yielded no information

that details this study's finding of existing emotion regulation strategies among the three Middle Eastern American client-participants.

Furthermore, few studies have examined the impact of regulating positive affect in daily life (Brans, Koval, Verduyn, Lim, & Kuppens, 2013). Brans et al. (2013) conducted two experience sampling studies and found that reflection was associated with increases in positive affect; reappraisal, distraction, and social sharing were also associated with increase in positive affect in one of the two studies. Results from our current dissertation study also appear to demonstrate that positive emotion regulation strategies, such as *Acceptance*, *Increasing Positive Emotional Events*, and *Labeling Current Affect* were associated with positive affect, as discussed below.

To further discuss this novel dissertation finding, the following subsections present novel within-group differences. We hope that this discussion spurs further study to investigate the possibility that certain emotion regulation strategies may be used cross culturally.

Sub-theme: Acceptance. Current literature on Middle Eastern individuals in psychotherapy lacks significant information about how this population utilizes acceptance as an emotion regulation strategy. One study examining the Farsi translation of the CERQ revealed that males scored higher on acceptance than did their female counterparts (Abdi et al., 2012), although not much was gleaned from this study regarding specific components of cultural understanding in utilization of acceptance. Within this dissertation study, the *Acceptance* category was coded 12 times and varied across client-participants.

The researchers defined the *Acceptance* category as acknowledgement of emotional, situational, or environmental difficulties without attempting to escape or avoid the respective situations. This coding-informed definition comports with the way acceptance is defined in the

psychotherapy emotion regulation models reviewed for this study. In accordance with ACT, acceptance, critical to emotion regulation, involves allowing a space to experience painful emotions without struggling or avoiding them (Harris, 2009). Linehan (2015) holds a similar view on acceptance, as DBT's *Increasing Mindfulness to Current Emotion* involves attending to and experiencing emotions without judging, blocking, inhibiting, or distracting them. Acceptance of and staying present with negative emotions are rooted in behavioral notion of exposure, as the increased ability to tolerate painful emotions without experiencing negative emotional reactivity ultimately reduces the generation of secondary negative emotions over time (Linehan 2015).

A possible trend across the CPs' data was seen in that later sessions showed a greater number of *Acceptance* codes than in first coded session. For CP1, *Acceptance* was coded once in session #0 and once in session #1. The following example of *Acceptance* was obtained from session #1:

C47: [Looks down, sighs]. Umm, well ever since I got into a relationship not as much. But um, I mean, that's just the way it goes. But I stay in contact with them. Yesterday was a birthday party of my friend's girlfriend so we all got together so. It seems like the only way these days you get people around – birthday or an event. So...[nods head] Not as much as you like, but it's just the way it is. You work. You have your own life to deal with now.

CP2's transcribed sessions revealed that *Acceptance* was coded twice in session #1 and three times in session #8. The following examples were taken from session #1 and session #8, respectively:

C43: Right, right. And I think I've worked through a lot of that stuff with [fiancé]. In previous relationships somebody does something that's hurtful and I don't even know how to talk to them afterwards. Now it's like okay you said and that's okay.

C44: And you move past it. Accept it.

Lastly, CP3's *Acceptance* codes also varied across his three transcribed sessions, as *Acceptance* was coded once in session #1 and four times in session #110. The excerpt below was obtained from session #110:

C156: I feel like that- I'm heading towards peace. Not a 100% peace but I'm heading towards there. Acceptance more so than peace.

T157: Mm-hmm

C157: With the occasional struggle here and there but that's being human being.

T158: It is.

C158: Anybody, whether you have therapy or not. That's there struggle. It doesn't make me weird if I struggle.

Thus, while *Acceptance* is not identified as a common cultural regulatory technique among Middle Eastern Americans, it may be hypothesized based on these findings that acceptance could represent a construct that is learned in therapy as emotions are explored and possibly regulated over time in the context of psychotherapy.

Sub-theme: Increasing positive emotional events. As found with the previous emotion regulation category, increasing positive emotional events is not a regulatory tactic that is described in the literature as specifically utilized by Middle Eastern individuals. This category was coded six times across the three participants. Examples of increasing positive emotional events among the three client-participants included maintaining friendships, watching movies, listening to music, and engaging in physical exercise.

As such, the researchers defined the *Increasing Positive Emotional Events* category as utilization of positive coping to facilitate emotional regulation. This category is considered by Linehan (2015) as a DBT emotion regulation skill, which is critical for emotion regulation as increasing positive emotions by increasing the amount of positive emotional events ultimately provides individuals with control over their own emotional states. In the present study, client-participants cited listening to music, exercising, relaxation, and spending time with friends and

significant others, which are also examples highlighted by Linehan (2015) as skills used to boost positive emotional states. Further, increasing positive emotional events promotes lifestyle changes that will serve to increase the frequency of positive events (Linehan, 2015).

Relative to the other *Emotion Dysregulation* and *Emotion Regulation* codes, *Increasing Positive Emotional Events*, was not frequently coded. Cognitive Behavioral Therapy for substance use disorders (Kiluk, Nich, Babuscio, & Carroll, 2010) and Dialectical Behavioral Therapy (U. Kramer, 2017) have been shown to increase the number of coping skills used by clients. In the present study, the therapists did not appear to be using any particular approach, with the exception of CP3's therapist, who appeared to use Cognitive-Behavioral Therapy to address CP3's symptoms of anxiety and depression. Thus, this finding may likely be due to several factors, such as client's goals, as well as therapist's unique style and experience.

Sub-theme: Labeling current affect. One of the most surprising findings in the current study pertained to the *Labeling Current Affect* category. Described as the ability to identify and express emotions experienced in the current moment, *Labeling Current Affect* was coded 17 times, more than double the codes for the *Difficulty Labeling Affect* category. This relatively high frequency suggests that the CPs were able to demonstrate a key emotional regulation skill across the three sessions. DBT is largely the only emotion regulation model that specifically contends that the ability to identify emotions experienced and to label them is a crucial aspect of emotion regulation (Carpenter & Trull, 2013).

This result was not expected because it represented a direct contrast to the current literature's view that Middle Eastern Americans typically conceal emotion. Among Middle Eastern populations, identifying and outwardly labeling affect is not culturally normative, according to the literature (Al-Krenawi & Graham, 2000; Dwairy, 2009; Nassar-McMillan &

Hakim-Larson, 2003). Concealment of emotion and suppressing one's own feelings are considered appropriate behaviors, as within Middle Eastern communities and families, discussion of the individual's feelings is considered to be a behavior against group norms (Abudabbeh, 2005; Gregg, 2005; Sayyedi et al., 2011). If individuals are not taught during their formative years to label and regulate emotional reactions, Linehan's (2015) Biosocial theory posits that these individuals learn over time to inhibit, escape, and avoid distressing and emotionally-provoking situations, which further exacerbates emotion regulation difficulties.

Furthermore, family honor and privacy are highly valued among Middle Eastern families, and seeking mental health services may be viewed as a violation of family privacy (Abudabbeh, 2005; Gregg, 2005; Sayyedi et al., 2011). As such, self-disclosure in the therapeutic setting may be seen as a violation of these values (Abudabbeh, 2005). However, this study's findings may indicate that within the psychotherapy setting, where disclosure of emotion is situationally appropriate, Middle Eastern Americans could view the setting as a private and confidential space to express emotions.

Also, acculturation factors should be considered when understanding these findings. Different levels of acculturation for each client-participant are unable to be conclusively determined based on the data available to the researchers. However, based on the data obtained from CP3's transcribed psychotherapy sessions, he likely could have valued self-disclosure as he was socialized as a clinical psychology student. In contrast, CP1, who did not label affect as much as other client-participants, may have inhibited other aspects of himself, including labeling of affect, as the therapist's disclosure of identity as Middle Eastern (her specific cultural identity was unknown) in conjunction with flirtatious dialogue, may have prevented him from disclosing

even further as she represented a member of his broader cultural community with potential for an outside relationship.

Emotion Categories

Current literature on Middle Eastern Americans' specific experiences of emotion is scant. Existing literature describes the inhibition/suppression of affect and negative emotional expression to be salient for Middle Eastern Americans (Abdulla & Brown, 2011; Al-Krenawi & Graham, 2000; Dwairy & Van Sickle, 1996; Haboush, 2005); however, not much is understood regarding a wider range of positive and negative emotions. This study's qualitative analysis of emotion regulation among Middle Eastern Americans uncovered specific emotional content in the client-participants' sessions that parallel findings within the current literature with this population, as well as new findings that reveal a wider spectrum of emotions experienced by this study's client-participants.

While the limited literature on Middle Eastern Americans suggests that depression is a condition that they experience (Nassar-McMillan & Hakim-Larson, 2003), and that depression, anxiety, and low self-esteem are directly linked to instances of discrimination (Amer, 2005; Moradi & Hasan, 2004; Padela & Heisler, 2010), few studies examine specific emotional content. Haboush (2005) noted gender differences for emotional expression among men and women. For instance, anger and aggressiveness are generally tolerated and accepted among Middle Eastern males; however, women are discouraged from expressing such emotions (Haboush, 2005). For Iranian families, shame can be used to discourage embarrassment to the family unit and to encourage obedience (Frank et al., 2010). In the current study, *Shame* was prevalent across all CPs, although more frequently inferred than expressed, with the exception of CP3 who appeared to express *Shame* in the same frequency as inferred by the researchers. In this

dissertation, researchers discovered findings that contradict current literature's assumptions that women are discouraged from expressing emotions (Haboush, 2005), as CP2, a female, expressed both positive and negative emotions during her three therapy sessions.

Further, while direct expression of emotions in public and in therapy is discouraged (Haboush, 2005), this study's analysis of emotion regulation among Middle Eastern American clients in psychotherapy revealed both expressed and inferred emotions for *Anger* ($n = 128$) and *Shame* ($n = 42$). Other negative emotions that were expressed and inferred included *Discomfort* ($n = 9$), *Fear* ($n = 81$), *Sadness* ($n = 35$), and *Guilt* ($n = 16$).

Across all three client-participants' transcribed sessions, negative emotions peaked in the second coded session or decreased in the third transcribed session. This finding may suggest that during the psychotherapy process, expression of negative affect was permitted or encouraged, allowing the client participant to unearth negative emotions. On the other hand, while expression of positive affect was welcomed and encouraged, therapists did not spend a significant amount of time further exploring positive emotion regulation. These findings may also reveal how the psychotherapy process is biased to focus on the experience and overcoming of negative emotions, as suggested by proponents of positive psychology (Fredrickson, 2001; Seligman & Csikszentmihalyi, 2000; Seligman, Steen, Park, & Peterson, 2005). As such, it can be hypothesized that the lack of interventions within the field of psychology aimed at helping clients to reflect on and express positive qualities, as well as the biases that many psychotherapists and researchers may hold towards psychopathology, may help to provide one possible explanation for this study's data that revealed a majority of negatively coded emotions.

While negative emotions constituted the highest frequency counts among all emotions ($n = 349$), the study also found a range of positive emotions that were both expressed and inferred

among all three client-participants ($n = 36$). Such emotions included *Happy* ($n = 29$), *Pride* ($n = 2$), *Hopefulness* ($n = 1$), and *Love* ($n = 4$).

In the present study, the occurrence of positive emotions across all three psychotherapy sessions appeared to vary across CPs. For instance, CP1's positive emotions of *Happy*, *Love*, and *Pride* trended downward in frequency by the end of the last psychotherapy session. For CP2 and CP3, however, positive emotions appeared to increase in frequency by the last psychotherapy session. There did not appear to be gender differences in positive emotion codes for all three CPs.

According to the literature on Middle Eastern Americans, expressions of affection and endearment towards the other are accepted and encouraged (Haboush, 2005). In addition to its cultural congruence, positive emotions have been shown to produce other benefits in a relatively new area of positive psychology research. Current literature on using positive emotions to regulate negative affect appears to have an important piece in addressing psychopathology (Fredrickson, 1998). The *broaden-and-build* theory, suggested by Fredrickson (1998) contends that the use of positive emotions encourages the use of a wider range of thought-action mechanisms and helps individuals to find new ways to change thoughts and/or actions. Positive emotions appear to have a strong role in combating negative emotions (Fredrickson & Levenson, 1998) and to encourage resilience (Tugade & Fredrickson, 2000). Further, according to Lazarus (1999), the use of hope can combat symptoms of depression, including hopelessness and despair.

Surprise ($n = 5$), a neutral emotion, also revealed to be a new finding within this study. Within the current literature, studies have been unable to conclusively determine if *Surprise* holds a positive or negative valence (Fontaine et al., 2007; Russell, 1980). These studies suggest that depending on the situation eliciting the emotion of *Surprise*, individuals can feel positive or

negative emotions. Noordewier and Breugelmans (2013) found that *Surprise* did not carry negative emotional weight in the way that *Sadness* or *Fear* can cause negative emotional reactions. The authors also concluded that while *Surprise* may carry negative weight, the interpretation and understanding of the *Surprise*-eliciting event by the individual can create a positive emotional experience (Noordewier & Bruegelmans, 2013). Surprise can also signal and/or trigger self-awareness, the need to take time to figure out what is happening and engage in metacognition (Foster & Keane, 2015; Reisenzein, 2000). Consistent with the above findings, data from this current study suggests that *Surprise* as experienced by the CPs had both positive and negative valences.

Inferred versus Expressed Emotions

As previously mentioned, within the Middle Eastern population, emotions are typically inhibited or suppressed (Abdulla & Brown, 2011; Al-Krenawi & Graham, 2000; Dwairy and Van Sickle, 1996; Haboush, 2005). For this reason, the researchers decided to not only include emotions clearly and verbally expressed by CPs, but also those observed by the researchers. Using this coding approach, findings from this current study revealed both concurrences and contradictions to this literature.

As described in the Results section, emotions were categorized by the researchers as inferred based on content of specific talk turns, and expressed as explicitly stated by the client-participant. Important to note in this study is the difference between expressed emotion and the parent theme of *Labeling Current Affect*. For example, CP1's total expressed anger codes ($n = 25$) were far greater than the number of codes for *Labeling Current Affect* ($n = 6$). The following examples of expressed Anger from session #0 illustrate this discrepancy:

C94: [interrupts therapist] not necessarily me. A lot of the issues start with her just blurting out random things at the wrong time in...in public. At public gatherings just to **irritate** me...

C103: Yeah. And nothing really bothers you because you don't care about anything. Nothing gets to you. When you're in a relationship there's an emotional attachment. So that thing **bothers** you, it...it kinda amplifies inside you.

In the examples above, *irritate* and *bothers*, were coded by the researchers as *Anger* per the Emotions Definition Manual (see Appendix H). In this example, the word *irritate* was expressed and not inferred; however, it did not qualify as a regulatory tactic of *Labeling Current Affect* as CP1 was not labeling feeling irritated in the current moment. In the second example, CP1 appeared to make use of the word *bothers* as enacted in the third-person, which supported the researchers' decision to not code this expression as a regulatory tactic.

Additionally, CP1's transcribed sessions revealed a decrease in positive emotions across consecutive psychotherapy sessions. Closer examination of the transcription indicated that in the third (and last) therapy session, the therapist appeared to push CP1 prematurely to accept his negative emotional experience of anger, and provided judgmental commentary about his interactions with his partner. This may also have ultimately led to increased negative feelings and suppression of emotion, as *Experiential Avoidance* increased substantially in the last session (#0, $n = 8$; #1, $n = 19$; #2, $n = 30$).

To highlight an example of a coded inferred emotion, consider the following example from CP2's session #8:

C20: Last night I started crying and had a long talk with him. It was really an emotional talk. We we're talking about how I've been feeling down lately and how a lot of it seems to be related to the wedding. And the fact that we're having this big wedding right now and I feel kind of isolated and guarded. I don't really feel like I there's anybody I can talk to or connect to and to be excited about the wedding. [Fiancé] was saying, "I wish we could postpone it" and I felt bad I wish I didn't feel this way. I wish this were something I could fix.

In the talk turn presented above, CP2 did not explicitly use the word “sad,” for example, to describe her emotional experience. Based on this talk turn and review of the phrases, “I started crying,” “It was really an emotional talk,” “...I’ve been feeling down lately,” “I don’t really feel like there’s anybody I can talk to or connect to,” the researchers coded the emotion *Sad*.

Additionally, while CP2’s positive emotions appeared to increase substantially in the third session, this likely was attributed to her discussion of the news of her pregnancy and reportedly improved relationship with her partner. Another hypothesis regarding the change in emotion codes is related to her desire to terminate treatment, which the researchers inferred based on her repeated attempts to end session early, and since this was the last session of psychotherapy.

In general, CP1’s and CP2’s transcribed sessions revealed that inferred emotions were coded with more frequency than expressed emotions. On the other hand, CP3’s most frequently coded emotion, *Fear*, was expressed with higher frequency ($n = 21$) than inferred by the researchers ($n = 12$). These differences in how and when negative and positive emotions were coded varied across client-participants may likely be due to various factors. Client-therapist dynamics and client diagnoses likely affect session content and trajectory; for example, CP3’s diagnosis of Social Anxiety Disorder and Persistent Depressive Disorder with Anxious Distress likely factored into the amount of times researchers coded *Fear* as expressed and inferred.

Consider the following examples to illustrate this point:

Session #1:

C39: Yeah. I feel like if people get to know me - I know it’s wrong. This is why it’s tough because I was educated and experienced in this field. I know I can receive some type of - even just self-therapy. Look at things differently, test things out, I understand that. It’s just the way I feel. Yes, I feel like if people got to know me - I’m **afraid** to be weak around them. I keep people at like an arms length away.

Session #51:

C9: I don't know. **Anxiety**. Depression a little bit too. I think that the **anxiety** of the depression is a result of my **anxiety**. You know what I'm saying? I don't think the depression is the cause - the depression is part of it. Yeah.

C29: Exactly. And I'm getting scared right now cause I'm - I'm lost. I'm lost.

Session #110:

C49: So then the nervousness came up. Okay. Now, I got to give this guy a call. And that's kind of a pain in the ass. "[Brother-in-law's name], thank you, but no." I just hate doing that. So it took me a couple days to figure out what I'm going to do in terms of how I'm going to let him know. So, you know, I'm going to text him in the morning.

Also, while CP3's last transcribed session indicated no positive emotions, it also revealed the least amount of negative emotions, including anger and fear. This likely indicates a decrease in negative affect over time in psychotherapy, despite the lack of positive emotion codes.

Within-Participant Session Content and Cultural Dynamics

Client-participant 1. As detailed in the results section, CP1 expressed having a difficulty with regulating his emotions, and also discussed his preference for keeping his difficulties and emotions private. CP1's preference to keep his relationship private, according to the literature, is culturally congruent for Middle Eastern individuals, as is concealing one's inner difficulties may bring upon shame to the individual, as well as to the family unit (Abudabbeh, 2005; Gregg, 2005; Jalali, 2005; Sayyedi et al., 2011). Additionally, the experience of shame was notable for CP1, especially when describing the actions of his partner, as he perceived her behaviors to be a direct reflection of him. CP1 also experienced shame in light of his own previous behaviors, and described feeling pained, embarrassed, and ashamed by his family. The concept of family honor and shame are salient factors for Middle Eastern families, as maintaining honor and upholding the family name is significant among Middle Eastern individuals (Abudabbeh, 2005; Frank et al., 2010; Gregg, 2005; Sayyedi et al., 2011). Sayyedi (2009) noted that Iranian families shape

behavior using shame or other forms of emotional control, as seen in the author's clinical and personal experiences.

Additionally, CP1 expressed pressures to become financially successful, which reportedly negatively impacted him. During his therapy sessions, he described the expectation that men are typically expected to be the "breadwinners." This notion is generally accepted to be true among Middle Eastern families, and is highlighted in the literature (Jalali, 2005; Sayyedi, 2009; Sayyedi et al., 2011).

Another significant dynamic that occurred between CP1 and his therapist was the use of self-disclosure. According to the literature on self-disclosure, over 90% of therapists self-disclose (Edwards & Murdock, 1994; Mathews, 1989; Pope, Tabachnick, & Keith-Spiegel, 1987). While this phenomenon appears to be common in the psychotherapy setting, the types of self-disclosure and implications of self-disclosure vary (Henretty & Levitt, 2010). Moreover, literature on self-disclosure stresses the importance of having a clear rationale for doing so (Henretty & Levitt, 2010). Take, for instance, CP1's therapist disclosure that she, too, was of Persian/Iranian descent. During session #0, upon self-disclosing, the therapist stated that she "gets it" when referring to cultural dynamics specific to the Iranian/Persian community. When having a clear rationale for self-disclosure, such as to promote therapeutic alliance, self-disclosure may be encouraged (Andersen & Anderson, 1989; Anderson & Mandell, 1989; Berg-Cross, 1984; Curtis, 1981; Hanson, 2005; Hill & Knox, 2001; Mahalik, Van Ormer, & Simi, 2000; J.C. Simon, 1988; Vamos, 1993; VandeCreek & Angstadt, 1985). This initially appeared to have pleased CP1, and some sources within the literature contend that an important factor when working with Middle Eastern Americans is to understand the individual's culture

(Abudabbeh, 2005; Dagirmanjian, 2005; Erickson & Al-Timimi, 2001; Jalali, 2005; Nassar-McMillan & Hakim-Larson, 2003).

However, ultimately this use of self-disclosure might have negatively impacted the alliance. For instance, current literature on Middle Eastern Americans in therapy reveal difficulties with emotional expression and avoidance of disclosure due to fear of experience of shame and violating honor to family unit (Abudabbeh, 2005; Gregg, 2005; Sayyedi et al., 2011). Thus, CP1 might have possibly viewed his therapist as a member of his community with a close degree of separation, ultimately causing him to “shut down” as seen in session #2. Adding to the complexity of dynamics between CP1 and his therapist were the frequent boundary violations that occurred across psychotherapy sessions, namely the flirtatious exchanges that were initiated by CP1 and entertained by the therapist. Moreover, use of self-disclosure is ill advised when participants of the therapeutic process have poor boundaries (Epstein, 1994; Goldstein, 1994), as seen between CP1 and his therapist, which might have possibly factored into the disruption of the therapeutic alliance.

Lastly, during CP1’s final psychotherapy session, the clinician attempted to engage in direct confrontation of his emotions, which may have caused him to shut down. According to the literature, when Middle Eastern Americans present to treatment, many might be unwilling to admit to psychological distress or experience of emotions due to feelings of shame or weakness (Nassar-McMillan & Hakim-Larson, 2003). Similarly, where the therapist inserted judgmental commentary about his relationship with his partner (e.g., “playing games”), CP1 may have experienced negative reactions to her comment, including perhaps shame, embarrassment, anger, or weakness. This could have led to disruption of the therapeutic alliance, as CP1 terminated psychotherapy following this session.

Client-participant 2. During her formative years, CP2 described feeling shame for being Persian, and she attributed the “ridicule” she experienced to her Romanian mother. CP2 described her mother’s opinions of Persian individuals as “loud and arrogant,” which negatively impacted CP2 at a young age. While in this example shame is not used by her mother as a tool to shape behavior and obedience, it nonetheless presents an example of some of the negative stereotypes Middle Eastern individuals face.

Moreover, during session #8, CP2’s therapist engaged in use of directives, presumably with the intent to provide direct advice. While current literature on Middle Eastern Americans in psychotherapy references the desire for direct advice to be salient with this population (Erickson & Al-Timimi, 2001), CP2’s therapist use of this intervention was perceived by the researchers as heavy-handed. Moreover, attempts were made during this particular session to help CP2 regulate her emotions (e.g., directing CP2 to practice deep breathing in session). However, at other times, the lack of collaboration between CP2 and her therapist, especially noted when the therapist provided her own opinions and beliefs, directly contradicts treatment recommendations as discussed in the current literature with this population. While directive psychotherapy is recommended by practitioners working with this population (Erickson & Al-Timimi, 2001; Jalali, 2005; Nassar & Hakim, 2003), the therapist will undoubtedly need to assess the client’s acculturative status to determine an effective treatment approach.

Further, as noted in the results section, the researchers observed that CP2 made indirect attempts to signal termination of treatment, but appeared unable to directly express this desired transition. For instance, she began session #16 (her last treatment session) by asking if she could end session early due to time limits on parking. The session was characterized as being chatty, with what researchers characterized as awkward moments between therapist and client, and

attempts to engage in therapeutic process were minimal. CP2 repeatedly informed her therapist that “everything is good” until ultimately deciding to end session early, citing concerns that she needed to return to work. Given the literature on Middle Eastern Americans’ desire for agreeableness and hospitality (Abdulla & Brown, 2011; Haboush, 2005), as well as avoidance of conflict (Al-Krenawi & Graham, 2000; Dwairy and Van Sickle, 1996; Haboush, 2005) it can be hypothesized that CP2 avoided direct confrontation with the therapist about termination of treatment.

Client-participant 3. An Iraqi-born male of Iranian and Israeli ethnicity, CP3 cited difficulties throughout his life belonging to one specific culture. CP3 also expressed feeling judged by his Iranian side of the family, and was often labeled as “white” due to his blue eyes and lighter skin tone. During one’s formative years, especially during the developmental adolescent period of identity development, individuals of ethnic minority status may experience added degree of stress navigating a social identity (French, Seidman, Allen, & Aber, 2006).

Similar to CP1’s therapist’s self-disclosure, CP3’s therapist appeared to have disclosed her ethnicity to CP3 at some point during the therapy process. CP3 attempted to relate his experiences to his therapist’s experiences in order to seek understanding from the therapist. In contrast to CP1 and his therapist, CP3 and his therapist appeared to have a strong therapeutic alliance over the span of three years in psychotherapy. It can be hypothesized that CP3’s therapist’s choice to self-disclose was deliberate to promote CP3’s disclosure, as described in the literature (Bundza & Simonson, 1973; Jourard, 1964, 1971; Mann & Murphy, 1975; M.J. Miller, 1983; Nilsson, Strassberg, & Bannon, 1979; Simonson, 1976), and to explore interpersonal dynamics (Bridges, 2001; Kohlenberg & Tsai, 1991; Linehan, 1993; McCullough, 2000)

especially in light of his diagnoses of Social Anxiety Disorder and Persistent Depressive Disorder with Anxious Distress.

As seen in CP1's transcribed sessions, CP3 frequently discussed feeling pressured to be successful, and appeared to endorse a degree of acculturation stress, namely cultural expectations (e.g., "It's the cultural thing") to become financially successful by a certain age. According to the literature on Iranians in the United States, they are often recognized for their high achievements in the fields of medicine, law, engineering, and other sciences, and it is typical for Iranian families to place pressure and expectations on their children to obtain accolades and social recognition (Jalali, 2005; Sayyedi, 2009). These pressures, which CP3 faced from this Iranian maternal side of the family, significantly contributed to the frequent social comparisons in which he often engaged.

At the midpoint of CP3's psychotherapy, he asked his therapist to deliver direct advice and recommendations to help him further explore his emotions. As previously mentioned, Middle Eastern Americans may be apt to ask the therapist for direct advice, as the therapist is viewed as the expert, akin to a physician (Erickson & Al-Timimi, 2001; Jalali, 2005; Nassar & Hakim, 2003). Furthermore, CP3's awareness and desire to enhance and deepen his emotional exploration could be rooted in his past as a former student in neuropsychology, and perhaps to his current status as an adjunct professor of psychology.

Limitations.

There were several limitations to the current study. This discussion reviews limitations related to inherent subjectivity in qualitative research, the coding of only some types of expressions, small sample size, and within-group differences among Middle Eastern Americans.

Subjectivity/Bias. First, while content analysis provides a subjective method to analyzing data (Krippendorff, 1980; Downe-Wamboldt, 1992; Sandelowski, 1995), its flexible approach allows for a wide range of guidelines for data analysis that can be potentially challenging for researchers to follow and implement (Elo & Kyngäs, 2008). As such, no guidelines exist for running analyses, and results depend on the data sets as well as the individual styles and skills of the researchers (Elo & Kyngäs, 2008).

Therefore, as the qualitative process is non-linear and non-standardized, potential researcher biases may arise. Although efforts were made to remain neutral and non-biased towards the data, it is without question that each researcher brought her individual set of values and biases that influenced the coding process. Moreover, different coders' biases and understanding of emotion, emotion regulation, and emotion dysregulation, especially related to the coders' own cultural identities and understandings of emotion, potentially influenced the coding process. One such example occurred during the first pass at open coding, as the primary researcher was more conservative in her approach to inferring emotions than the other researcher and auditor of the study. Additionally, at times, the other researcher and the auditor of the study coded other forms of emotion regulation that the primary researcher initially did not grasp (e.g., self-talk as a regulatory process). Further, as the primary researcher of the study self-identified as Middle Eastern American, she was more sensitive to cultural dynamics at play within the session, and at times identified similar experiences between her own history and the content of the client-participant's transcribed sessions.

To minimize negative effects of biases, bracketing provided a way for the researchers to independently journal thoughts, feelings, and reflections during the coding process. The aforementioned examples were also highlighted in the audit trail, which provided a way for the

researchers and auditor to engage in back-and-forth conversation uncovering biases and engaging in reflections, as well as finalizing decisions on coding matters. For example, the audit trail revealed detailed discussion about emotion definitions, questions about specific ways to code for emotion regulation, decision points and action items, and literature suggestions to further understanding of these concepts. Moreover, in order to create the coding manual, the researchers acknowledged the difficult balance between creating definitions and guidelines for coding emotion, emotion regulation, and emotion dysregulation, all while remaining open to the inductive process of coding and mindful of ways to minimize drift into deductive coding. The researchers acknowledge that our approach led to the use of the terms *Emotional Regulation* and *Emotional Dysregulation* as Parent Themes, and support future research to further explore construct validity of these constructs in the Middle Eastern and Middle Eastern American populations.

Lastly, with respect to inter-rater reliability, the researchers initially agreed to calculate inter-rater reliability for each coding domain; however, ultimately, group consensus on codes was utilized as the researchers engaged in multiple passes and discussion of the data to agree upon codes. Thus, while consensus was reached, no hard data can be presented to demonstrate intercoder agreement.

Non-exhaustive coding. Another potential limitation of the coding system is that the researchers focused on verbal expressions of emotional regulation and dysregulation only. As such, it likely underrepresented the client's specific thoughts as well as emotions that were not observable or verbally articulated. However, the researchers engaged in coding of expressed and inferred emotion, wherein the process of inferring emotion relied on the researchers' interpretations of the talk-turns. In this way, by quantifying both inferred and expressed

emotions, researchers were able to obtain a sense for the difference in frequencies between inferred and expressed emotions across the three client-participants. Further, because InVivo coding was not used to form specific Emotion and Emotion Regulation codes, the client-participant's nuanced communication and verbal expressions were likely underrepresented, as the researcher focused on the experience of emotions and emotion regulation. As previously mentioned, while this remained an inductive process, researchers coded for emotion regulation/dysregulation as informed by approaches gleaned from the literature, which may be viewed as a deductive process that may have limited what was gathered from the data.

Additionally, the quality of the videotaped sessions may have prevented the researchers from accurately observing the client's facial and bodily behaviors that were relevant to the study's aim to explore emotion regulation as exhibited by Middle Eastern American clients. Furthermore, the clinic's lack of biological measures to assess the client's internal emotional state prevented the researchers from being able to gather instances of emotion regulation and dysregulation that were not readily observable.

Sample size. A third limitation of the study is its small sample size, which may prevent generalizability of the findings. However, the goal of the study was not to generalize the findings; rather, it was to provide more information regarding how emotion, emotion regulation, and emotion dysregulation were evidenced in psychotherapy sessions by individuals of Middle Eastern descent. Moreover, a qualitative approach allowed for the relation of each CPs' unique experiences that can further understanding of how emotion regulation is evidenced with this population.

Another limitation of the small sample size was the lack of gender balance among the client-participants. The study initially sought to obtain a sample of approximately two males and

two females; however, due to lack of availability of working DVD files, the sample was limited to two males and one female. Furthermore, the study initially sought to obtain a wider sample of Middle Eastern identities in order to observe phenomena across various individuals of Middle Eastern descent.

Additionally, due to the availability of working DVD files, each client participant varied in terms of number of total psychotherapy sessions. For instance CP1 attended a total of three sessions, CP2 attended 16 sessions, and CP3 attended 112 sessions. The study initially sought to obtain a sample of how emotions were expressed and/or regulated across time; however, due to the variations of total number of sessions for each of the three participants, no conclusions could be made regarding emotional expression and emotion regulation with length of time in treatment.

Within-group differences. Finally, the broad focus on the Middle Eastern demographic in the present study embraced the cultural definition of a large geographical area that represents many different religions, ethnicities, and subcultures. The researchers tried to take into account the large within group differences with the Middle Eastern American population. Since the sample derived consisted of three self-identified Persian/Iranian client-participants, the primary researcher obtained additional data and literature on Iranians/Persians in the context of psychotherapy. Unfortunately, as observed with the literature on Middle Eastern individuals in psychotherapy, even less is known about counseling Iranians/Persians as well as the specific domains of emotion and emotion regulation with this population than is known about Arab Americans. The lack of sufficient empirical literature with this population potentially impacted the primary researcher's ability to corroborate observations with what is empirically known related to emotion and emotion regulation with this population.

Contributions and implications. This current study was the first to examine the experience of emotions and emotion regulation with Middle Eastern American psychotherapy clients, with the aim to provide novel findings and to remediate the lack of literature on assessment and psychotherapy with this population. After these contributions are reviewed, implications of findings for psychotherapy are presented.

Contributions. As previously noted, despite the growing need for mental health services, Middle Eastern Americans are widely underrepresented in the psychotherapy literature. The extant literature on psychotherapy with this population appears to lack empirical data, and focuses on professional opinions and theories about what psychotherapists should do when working with this population. Moreover, the American Psychological Association's guidelines for developing and implementing cultural competency in practice do not provide specific suggestions for working with individuals of Middle Eastern descent. The access to observable data from actual psychotherapy sessions in the present study, rather than relying on the experiences of therapists working with this population as represented in the current literature on Middle Eastern American individuals in treatment, allowed for the collection and sharing of new data regarding clients from this population generally as well as specific to their expressions of emotion and emotion regulation.

First the present study led credence to the understanding that emotion is generally inhibited or suppressed in this population, as disclosing personal problems and expressing emotion to an individual outside of the family sphere can be experienced as disloyal and/or shaming (Abdulla & Brown, 2011; Al-Krenawi & Graham, 2000; Dwairy and Van Sickle, 1996; Haboush, 2005). Data from this study corroborate information from the literature on Middle Eastern Americans, as researchers uncovered that the client-participants often avoided and

suppressed experience of emotion, exhibited difficulty with labeling affect, and endorsed emotions of shame and anger.

At the same time, however, this qualitative study uncovered new findings that contradicted existing recommendations for psychotherapeutic treatment with Middle Eastern American psychotherapy clients, as suggested by the current opinion-based literature. First, the current study revealed that the client-participants were able to identify and express emotions in the current moment at a relatively high frequency. This result was not expected because it represented a direct contrast to the current literature's view that Middle Eastern Americans typically conceal emotion. Additionally, the study uncovered other emotion regulation strategies, such as *Acceptance* and *Labeling Current Affect*, which are not widely discussed in the literature as regulatory strategies used by this population but are shown to combat the effects of emotional disorders. As such, this study's finding of such healthy strategies is significant because much of the literature describing affective expression of emotion among Middle Eastern individuals falls under the *Emotion Dysregulation* umbrella.

It should be noted that certain cultural groups may not label or view emotion dysregulation in a negative light; thus, this possibly may represent an issue of construct validity when examining emotion regulation among different cultural groups. While this study defined *Emotion Dysregulation* as a maladaptive strategy that induces or is related to negative emotional experiences for the particular client-participant, closer examination of the functions of certain behaviors within specific cultural groups is warranted.

In terms of emotions, another novel finding from the present study centered around the discovery of positive emotions. While current literature appears to lack information on how Middle Eastern Americans express positive emotions, this study uncovered that the client-

participants endorsed *Happy*, *Pride*, and *Love*. Although these emotions and their frequencies varied across CPs, they nonetheless represent a new addition to what and how positive emotions are endorsed in this sample of the Middle Eastern American population.

Regarding negative emotions, results highlighted their frequent occurrence in actual psychotherapy sessions, especially as compared to positive emotions. In addition, their pattern across time was noted as typically peaking in the second transcribed session and/or decreasing in the third transcribed session, which may indicate that the process of psychotherapy was biased to address the experience of negative emotions instead of focusing on positive emotions to overcome psychopathology (Fredrickson, 2001; Seligman & Csikszentmihalyi, 2000; Seligman et al., 2005). It may also signal the therapist's bias to focus on negative emotions and a lack of interventions in his/her repertoire to utilize positive emotions in order to facilitate emotion regulation. These findings and observations represent an implication for treatment with both the Middle Eastern population and beyond, as an opportunity for therapists to consider utilizing positive psychology techniques.

Implications for psychotherapy. The aforementioned novel findings reveal several implications for treatment with the Middle Eastern American population in psychotherapy, in addition to the recommendation just noted above to include positive emotions in assessment and treatment. First, in light of the new findings discussed above, it is imperative for the clinician to assess the client's level of acculturation. Depending on acculturative status, targets for treatment, will vary, and it is crucial for the clinician to consider a thorough assessment. One example from this current study demonstrated the significant stressors and anxiety CP3 experienced as a result of cultural expectations to become financially successful. This represented a noteworthy area for the therapist to engage in exploration of emotions and acculturative stress simultaneously. Thus,

when assessing acculturation and engaging the client in discussion regarding emotions and emotion regulation, the clinician should also gather information pertaining to family dynamics, such as rules and implicit codes that affect the expression of emotion.

Moreover, as observed in the dynamic between CP1 and his therapist, clinicians should avoid repeated or strong confrontation with their clients in an attempt to impart change based on the therapists' own values. The therapist should avoid use of what may be perceived to be judgmental remarks about the client and his/her family dynamics, even if the therapist perceives certain client cultural variables to be counter to his/her own values. Collaboration with the Middle Eastern American client is advised, and by exploring the client's values, the clinician may embark on a strong therapeutic journey with the client in a culturally sensitive and appropriate manner.

Secondly, in consideration of the heterogeneity of Middle Eastern Americans, clinicians should attempt to understand the client's individual sub-culture, including religion, socioeconomic status, intergenerational trauma, and other factors contributing to the unique make-up of the individual. These cultural facets may factor into treatment and could further the clinician's understanding of the individual's innate ways of regulating his/her emotions. Moreover, we believe that obtaining an understanding of experienced prejudice, discrimination, trauma, intergenerational trauma, or immigration traumas, can facilitate dissemination of appropriate emotion regulation strategies (e.g., culturally-adapted exposure and/or cognitive-exposure techniques).

Third, Middle Eastern Americans are often negatively stereotyped in the media, especially post 9/11 and in the current sociopolitical climate; thus, it is crucial that the clinician engage in a self-assessment to recognize his/her own biases when working with this population.

By utilizing a non-judgmental stance, remaining open, and being inquisitive about the individual's culture and experiences, these recommendations for culturally sensitive and empathic care can provide fertile ground for the cultivation of a strong working alliance, trust, and opportunity to facilitate helpful emotion regulation strategies when working with this population.

Fourth, when considering the use of self-disclosure, the clinician should decide on the purpose and utility of self-disclosing. Should the goal of self-disclosure be used to promote therapeutic alliance, it may be used judiciously (Andersen & Anderson, 1989; Anderson & Mandell, 1989; Berg-Cross, 1984; Curtis, 1981; Hanson, 2005; Hill & Knox, 2001; Mahalik et al., 2000; J.C. Simon, 1988; Vamos, 1993; VandeCreek & Angstadt, 1985). However, careful consideration should take place when disclosing one's own ethnic background to the Middle Eastern client, especially if the client and therapist belong to the same community, as issues of and concerns for privacy may hinder the therapeutic process (Abudabbbeh, 2005; Gregg, 2005; Sayyedi et al., 2011). Additionally, maintaining appropriate boundaries while utilizing therapist self-disclosure (Epstein, 1994; Goldstein, 1994) will hold true for the Middle Eastern psychotherapy client, as evidenced in the session between CP1 and his therapist.

Future Directions

Future studies investigating emotion and emotion regulation in Middle Eastern psychotherapy clients could redress some of the limitations of the current study. First, due to the limited number of sessions observed during research and analysis, future research may find it useful to code themes of emotion and emotion regulation across consecutive therapy sessions in order to obtain a clear picture of the frequencies and occurrences of these variables within and across time. For example, research questions could explore the relative frequency of negative

and positive emotions and regulation strategies, and their relationship to length of therapy, therapist orientation and client acculturation status. For example, a potential research question examining treatment time and emotions could be, “How does length of time in treatment change the frequencies of positive and negative emotions?” To that end, researchers should attempt to assess constructs of emotion regulation and emotion dysregulation with specific cultural groups to understand what is culturally normative and/or adaptive in order to obtain a clearer sense of the functions of emotion, emotion regulation, and emotion dysregulation. This can also help to address issues of construct validity that may arise when applying specific definitions of these categories to various cultural groups.

Secondly, during psychotherapy an explicit inclusion of positive emotions and positive emotional regulation is encouraged by the novel findings in the present study as well as Fredrickson’s research on positive emotions and *broaden and build* theory. In the present study, a range of positive emotions were coded. Since they were expressed far less than inferred, this result highlights a potential need for clinicians to help the client engage in positive affect exploration. A potential research question to explore the use of positive emotions with Middle Eastern psychotherapy clients could be, “How does the use of positive emotions in psychotherapy help to combat the negative emotional experiences afflicted by Middle Eastern Americans?”

Also, as discovered in this current study, *Surprise* was coded as expressed and inferred, and appeared to have a positive or negative valence. In a previous study conducted by Machado, Beutler, and Greenberg (1999), experienced therapists appeared to correctly code for anger, fear, love, joy, sadness; however, while anger, joy, and love were rated with the highest level of agreement, none coded for surprise. Thus, in order to facilitate exploration of the interpretation

and understanding of the *Surprise*-eliciting events, clinicians and researchers should also consider how to effectively assess this emotion in the context of psychotherapy. Although observational coding systems are available (e.g., facial muscles – FACS; Ekman & Rosenberg, 1997), measuring the subjective experience is also considered valuable as capturing this aspect of surprise has been related to self-awareness and meta-cognition (Reisenzein, 2000). Such constructs and experiences are ideally integral to the psychotherapeutic process, regardless of therapeutic modality.

Third, while qualitative research is not concerned with frequencies, it may hold true that important data pertaining to emotion and emotion regulation were not captured in non-transcribed sessions. For example, non-verbal behaviors (e.g., body language), internal processes, and client-self report data could have likely contributed to and aided to the study's understanding of emotion regulation with this population.

Fourth, because Middle Eastern Americans are miscategorized under the Caucasian umbrella in some research, researchers considering the study of various cultural variables in therapy and assessment should make efforts to account for Middle Eastern identity when attempting to obtain a diverse sample of participants. Although Middle Eastern individuals share similar values and cultural beliefs, it is a heterogeneous group with large within-group differences. As such, future research should consider studying emotion and emotion regulation among specific subcultures of the larger Middle Eastern culture. An example of this would be to obtain a sample of Arab American participants and compare this sample to Iranian/Persian American participants in order to understand differences in emotion regulation. A research question could be “Are there emotion regulation differences between Arab Americans and Iranian/Persian Americans?” Moreover, future research should also examine differences between

different generations of Middle Eastern Americans as well as different levels of acculturation to understand intergenerational factors that factor into therapy. Other relevant cultural variables to this demographic include gender, language, religion, nationality, and socioeconomic status.

Fifth, as observed in this current study, therapist variables impact the psychotherapeutic process. One such variable to consider for future research would be to examine the therapist's specific culture, values, attitudes, and beliefs, and develop research questions and/or hypotheses to explore how these variables impact psychotherapy with Middle Eastern clients. These variables may be measured with the use of assessment measures or qualitative tools, such as interviews, in order to gather data about how one's own belief system impacts dissemination of care to clients of Middle Eastern descent. For instance, one inference generated from this study was how CP1's therapist's belief system about relational dynamics and expression of emotion may have affected treatment for CP1, as the researchers observed that the ensuing contentious exchanges between therapist and CP1 factored into termination. Further, while CP1's therapist's use of self-disclosure and poor boundaries may have negatively impacted the therapeutic process, CP3's therapist's use of self-disclosure potentially aided in his treatment. Thus, a research question generated from the present study could be "How does the use of therapist self-disclosure help or harm psychotherapy with Middle Eastern Americans?" Another area for future study would be to explore therapist factors and dynamics that account for missed opportunities to engage the client in facilitation of emotional expression and/or examining to what extent the therapist contributes to emotion dysregulation. Thus, the collection of multiple sources of data can inform future researchers and clinicians to be mindful of specific factors that may impede or facilitate treatment.

Lastly, a sixth area for future research with the Middle Eastern population would be to better understand efficacy of various psychotherapies, including mindfulness-acceptance approaches and Evidence Based Treatments (EBT), by gathering data regarding therapeutic outcomes. Much of the current literature's recommendations for treatment is based on authors' views and opinions of how to treat individuals of this population, such as Abudabbeh's and Hays' (2006) recommendation of CBT over insight-oriented approaches. Future studies comparing CBT, DBT, ACT, and other Mindfulness-Based treatments with insight-oriented approaches could test the hypothesis that CBT would yield better outcomes, such as stronger therapeutic alliances, greater symptom reduction and increased positive affect and adaptive coping when compared to the use of insight-oriented psychotherapy. While this study focused on how emotions are expressed and/or regulated by individuals of Middle Eastern descent, and not therapeutic outcomes, it would be valuable to understand in practice which therapeutic modalities are most efficacious with this population, and which can be adapted taking into consideration all of the cultural dynamics that factored into emotion regulation (e.g., experiential avoidance, acceptance, labeling current affect).

Conclusion. In conclusion, it is hoped that the findings of this study, which both confirmed and contradicted literature on Middle Eastern Americans, will provide clinicians with further knowledge of how to understand, assess, and facilitate regulation of emotion with this population. It is further hoped that the study of emotions and emotion regulation will be further explored with Middle Eastern Americans in order to redress the continued gap in the literature regarding this population, as well as to hopefully combat stereotypes often portrayed to Middle Eastern individuals. By spurring research and practice with these individuals, it is also hoped that

the stigma associated with receiving mental health services will be lessened in order to disseminate services to a population that is widely underrepresented.

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Appendix A

Client Consent for Research

**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 copy of the Notice of Privacy Practices (NPP) 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/tenth 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.

I have read the above, and understand and agree to being video/audio taped for teaching and training purposes.

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, including those that are sent to you after you end services at the clinic, 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. Despite the confidential use and storage of these tapes by approved personnel, it is still possible for identifying information to be recorded into the content of these videos (e.g., faces, names and other identifying information audibly and visually produced in psychotherapy sessions). As a result, 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.

For the purposes of including information in the Research Database, please circle “yes” or “no” below, indicating your willingness to participate in each of the following:

Written Data: Yes No

Videotaped Data: Yes No

Audiotaped Data: Yes No

I understand and agree to being contacted in the future about the opportunity to participate in other specific research programs:

Yes No

Fees: The fee for the initial intake is nonrefundable. Payment for services is due at the time the services are rendered. Your 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 (PHI) 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.

The Health Insurance Portability and Accountability Act (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 Notice of Privacy Practices 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.

Signature of client, 18 or older
(Or name of client, if a minor)

and/or

Signature of parent or guardian

Relationship to client

Signature of parent or guardian

Relationship to client

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

Clinic/Counseling Center
Representative/Witness

Translator

Date of signing

Appendix B

Therapist Consent for Research

**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 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 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 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 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 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 Interview

Pepperdine Community Counseling Center

Telephone Intake Interview

GA/INTERVIEWER: BEFORE YOU BEGIN THE PHONE INTAKE, BE SURE TO GO OVER THE HIGHLIGHTED SECTIONS OF THE PHONE INTAKE CHECKLIST AT THE END OF THIS FORM. SOME CALLERS CHOOSE TO OPT OUT OF SERVICES UPON BEING INFORMED ABOUT THE SPECIFICS OF SERVICES AT OUR CLINIC.

Confidentiality Agreement

"Before we begin I have to tell you a few things about confidentiality and its limits during this phone intake. Everything you describe to me during this intake is confidential and will only be shared with my supervisor and the therapist assigned to you. However, if I begin to understand that your safety, a child's safety, or the safety of any other person is at risk, I might not be able to keep your confidentiality and might have to take steps to assure that everyone is safe. Do you have any questions about this?"

DOES THE CALLER HAVE ANY QUESTION/CONCERNS REGARDING CONFIDENTIALITY? ☐ Y ☐ N

Caller Information

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

CALLER'S

NAME?: _____

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

_____ ☐ M ☐ F DOB: _____ AGE: _____

IF CALLER IS A MINOR, WHAT IS THE CALLER'S RELATIONSHIP TO (CLIENT'S

NAME)?"? _____

WHAT IS CALLER'S ADDRESS?:

WHAT IS CALLER'S CONTACT NUMBER(S): _____ (CELL)

_____ (HOME)

_____ (CELL)

_____ (HOME)

<input type="checkbox"/> Adult	<input type="checkbox"/> Child	<input type="checkbox"/> Adolescent	<input type="checkbox"/> If we ever needed to
<input type="checkbox"/> Individual	<input type="checkbox"/> Couple	<input type="checkbox"/> Family	<input type="checkbox"/> Group

CONTACT YOU, WOULD IT BE ALRIGHT IF WE LEFT A VOICEMAIL ON YOUR PHONE IDENTIFYING OURSELVES AS BEING FROM A COUNSELING CENTER? ☐ Y ☐ N IF NOT HOW CAN WE REACH YOU? _____

WHO DOES (CLIENT) LIVE WITH? ☐ SELF ☐

OTHERS: _____

DOES (CLIENT) HAVE CHILDREN?: ☐ Y ☐ N IF YES, HOW MANY, AGES, DO THEY LIVE WITH THE CALLER, WITH THE SAME PARTNER, STILL IN CONTACT WITH CHILDREN?

IF YOU WERE EVER HAVING A BAD DAY OR NEEDED SOMEONE TO TALK TO, WHO WOULD YOU INCLUDE IN YOUR SUPPORT SYSTEM?

SOME PEOPLE FIND IT HELPFUL TO SHARE CERTAIN WAYS THEY IDENTIFY THEMSELVES. THIS MIGHT INCLUDE PARTICULAR ETHNICITY, RACE, RELIGION, LGBT-Q IDENTIFICATION, OR ANOTHER GROUP WITH WHICH THEY IDENTIFY. WOULD YOU LIKE TO SHARE ANY ASPECT OF YOUR IDENTITY THAT IS IMPORTANT TO YOU?

Type of Service

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

IS THERE A STRONG PREFERENCE FOR A PARTICULAR TYPE OF THERAPIST (I.E., GENDER, LGBT-Q ORIENTATION, RACE, ETHNICITY, LANGUAGE OR ANY OTHER ASPECT OF CULTURE THAT IS IMPORTANT TO YOU)? "IT IS NOT ALWAYS THE CASE THAT WE CAN ACCOMMODATE SUCH PREFERENCES. IF AND WHEN WE HAVE AVAILABLE THERAPISTS, WE WILL CONSIDER CLIENT PREFERENCES IN ASSIGNING A THERAPIST."

IS THIS COURT-MANDATED/ORDERED THERAPY? ☐ Y ☐ N IF YES, FOR WHAT REASON?

****IF SO, WE ARE UNABLE TO ACCOMMODATE ANY COURT ORDERED REFERRALS. HOWEVER, I AM ABLE TO PROVIDE YOU WITH A FEW POTENTIAL REFERRALS THAT MIGHT BE OPEN TO TAKING A COURT-MANDATED CASE.****

IF YOU WERE TO COME TO OUR CLINIC, WHAT WOULD BE THE BEST DAYS AND TIMES TO MEET WITH YOUR THERAPIST? (*MUST HAVE A BROAD AVAILABILITY*)

Legal History

DO YOU HAVE ANY PAST OR CURRENT LEGAL CONCERNS/ISSUES SUCH AS A DUI, DRUG POSSESSION, OPEN COURT CASES, CHILD CUSTODY DISPUTES, DCFS

INVOLVEMENT): ☐ Y ☐ N

Suicidality Assessment

GA/INTERVIEWER: PLEASE REMEMBER THAT SPEAKING OF SUICIDAL IDEATION IS NOT EASY FOR MOST CALLERS. PLEASE ADDRESS WITH SENSITIVITY AND AWARENESS THAT RELIGION AND CULTURE PLAY A ROLE IN HOW PEOPLE WILL RESPOND TO YOUR QUESTIONS. CONSIDER ALTERNATIVE WAYS OF ASKING ABOUT IT WHEN APPROPRIATE (E.G., "THOUGHTS ABOUT NOT WANTING TO LIVE ANYMORE", "THOUGHTS ABOUT DEATH")

DO YOU CURRENTLY HAVE THOUGHTS ABOUT HURTING YOURSELF/KILLING YOURSELF/ENDING YOUR LIFE? ☐ Y ☐ N

***IF SO, IMMEDIATELY ASSESS RISK AND GIVE CALLER THE SUICIDE PREVENTION HOTLINE # AND INSTRUCT THEM TO CALL (1-800-784-2433) OR**

GO TO NEAREST EMERGENCY ROOM.

HAVE YOU EVER THOUGHT ABOUT HURTING YOURSELF/KILLING YOURSELF/ENDING YOUR LIFE IN THE PAST? ☐ Y ☐ N

IF YES, WHEN, DID YOU HAVE A PLAN OF HOW WERE YOU GOING TO DO IT, HOW OFTEN HAVE YOU THOUGHT ABOUT IT?

HAVE YOU EVER ATTEMPTED SUICIDE IN THE PAST? ☐ Y ☐ N IF SO, WHEN, HOW DID YOU DO IT, HOW MANY TIMES HAVE YOU TRIED, DID ANYONE ELSE KNOW, WERE YOU HOSPITALIZED?

HAVE YOU EVER ENGAGED IN SELF-HARMING BEHAVIOR (I.E. CUTTING, BURNING, HITTING, OR PINCHING SELF)? ☐ Y ☐ N

Alcohol and Drug Use

WHAT IS YOUR CURRENT CONSUMPTION OF ALCOHOL? *BE SPECIFIC ON FREQUENCY, SETTING, TYPE OF ALCOHOL (BEER, SHOTS, WINE, ETC.), SOCIAL VS. ALONE. DOES THE CALLER THINK THE AMOUNT OF CONSUMPTION IS AN ISSUE? HAS ANYONE CLOSE TO CALLER NOTED THIS IS AN ISSUE FOR CALLER?

WHAT IS THE ONSET AND HISTORY OF CONSUMPTION?

WHAT IS YOUR CURRENT USE OF DRUGS, IF ANY? *BE SPECIFIC ON FREQUENCY, SETTING, TYPE OF DRUGS (INCLUDING PRESCRIPTION DRUGS), MODALITY (INHALATION [JOINT, PIPE, HUFFING], INTRAVENOUS, ETC.), SOCIAL VS. ALONE. DOES THE CALLER THINK THE AMOUNT OF CONSUMPTION IS AN ISSUE? HAS ANYONE CLOSE TO CALLER NOTED THIS IS AN ISSUE FOR CALLER?

WHAT IS THE ONSET AND **HISTORY** OF CONSUMPTION?

DO YOU FEEL OR HAVE OTHERS SUGGESTED THAT YOUR PAST OR CURRENT **ALCOHOL** USE HAS HAD AN ADVERSE IMPACT ON YOUR LIFE? ☐ Y
☐ N

DO YOU FEEL OR HAVE OTHERS SUGGESTED THAT YOUR PAST OR CURRENT **DRUG** USE HAS HAD AN ADVERSE IMPACT ON YOUR LIFE? ☐ Y
☐ N

Temperament, Violence and Potential Domestic Violence

DO YOU FEEL OR HAVE OTHERS SUGGESTED THAT YOU HAVE A “BAD TEMPER” OR THAT YOU GET ANGRY EASILY? ☐ Y ☐ N

IF SO, IN WHAT SORTS OF SITUATIONS DO YOU TEND TO GET UPSET?

HAVE YOU EVER BEEN VIOLENT OR PHYSICAL WITH ANOTHER PERSON? ☐ Y ☐ N

IF YES, HAS ANYONE GOT PHYSICALLY HURT? BRUISED? WAS MEDICAL ATTENTION NEEDED? ☐ Y ☐ N

SPECIFY WHAT THE VIOLENCE WAS: SLAPPING, CLOSED-FISTED/OPEN-HANDED HITTING, PUSHING, CHOKING, ETC.

HAS SOMEONE ELSE EVER BEEN VIOLENT OR PHYSICAL WITH YOU? ☐ Y ☐ N

IF YES, HAS THE PERSON EVER LEFT A MARK OR BRUISE, WAS MEDICAL ATTENTION NEEDED? ☐ Y ☐ N

SPECIFY WHAT THE VIOLENCE WAS: SLAPPING, CLOSED-FISTED/OPEN-HANDED HITTING, PUSHING, CHOKING, ETC.

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

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 LEGAL DOCUMENTATION AVAILABLE THAT YOU CAN BRING TO THE INTAKE SESSION TO HELP SUPPORT THE CUSTODY ARRANGEMENT YOU ARE DESCRIBING? ☐ 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

Reason for Referral

TELL ME ABOUT THE REASON(S) YOU ARE SEEKING SERVICES HERE AT OUT CLINIC:

[illegible]

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: _____

Closing Statement

- ☐ I INFORMED THE POTENTIAL CLIENT THAT THE THERAPISTS ARE UNLICENSED DOCTORAL STUDENTS WHO ARE SUPERVISED BY LICENSED CLINICAL PSYCHOLOGISTS.
- ☐ I INFORMED THE POTENTIAL CLIENT THAT ALL SESSIONS ARE AUDIO AND VIDEO RECORDED AND ARE USED FOR TRAINING PURPOSES. I EXPLAINED THAT ONLY THERAPISTS AND THEIR SUPERVISORS (LICENSED CLINICAL PSYCHOLOGISTS) REVIEW THE RECORDINGS AND THEY ARE DESTROYED AT THE END OF CLIENT'S TREATMENT, UNLESS THE CLIENT GIVES US WRITTEN PERMISSION TO SAVE THEM FOR TRAINING AND/OR RESEARCH PURPOSES.
- ☐ I INFORMED THE POTENTIAL CLIENT OF THE NON-REFUNDABLE \$25.00 INTAKE SESSION FEE
- ☐ I INFORMED THE POTENTIAL CLIENT THE CLINIC OPERATES ON A SLIDING SCALE WHICH IS BASED ON THEIR YEARLY INCOME AND RANGES FROM \$15-\$90 PER SESSION.
- ☐ I INFORMED THE POTENTIAL CLIENT THAT THE INTAKE SESSION WILL BE 2.5 HOURS IN LENGTH. THE CLIENT WILL SPEND THE FIRST 45 MINUTES TO AN HOUR FILLING OUT PAPER WORK AND AFTERWARDS, WILL MEET WITH THEIR THERAPIST. I ALSO INFORMED THE POTENTIAL CLIENT OF THE IMPORTANCE OF ARRIVING PROMPTLY FOR THE SESSION.
- ☐ I INFORMED THE CLIENT THAT FOLLOWING THE INTAKE SESSION, THE THERAPIST WILL PROVIDE THEM WITH FEEDBACK ABOUT AND MAKE TREATMENT RECOMMENDATIONS WHICH MAY INCLUDE CONTINUED TREATMENT AT THE CLINIC OR REFERRALS TO ANOTHER CLINIC
- ☐ I INFORMED THE CLIENT THAT THEIR THERAPIST WILL ASSIGNED SOMEWHAT BASED ON AVAILABILITY AND SCHEDULE FLEXIBILITY

"Thank you for your time and for sharing very personal information with me. From here, I will present your intake to my supervisor/clinic director and she will assess if the clinic is a good fit for your therapy needs. If so, your case will be assigned to a therapist that will contact you within 1-2 days. Otherwise, someone will call you back to provide appropriate referrals to other clinics. If you have any questions or concerns, please feel free to call the clinic. We will try to be in contact with you within the next 1-2 days. Thank you."

Case Assignment

ASSIGNED TO: _____ BY: _____ DATE: _____

ASSIGNED THERAPIST - PLEASE DOCUMENT ATTEMPTS TO CONTACT:

Appendix D

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 ? <input type="checkbox"/> Y
		_____	<input type="checkbox"/> N
	(WORK): _____	BEST TIME TO CALL: _____	CAN WE LEAVE A MESSAGE ? <input type="checkbox"/> Y
		_____	<input type="checkbox"/> N

AGE: _____ DATE OF BIRTH ____/____/____

MARITAL STATUS:			
<input type="checkbox"/> MARRIED	<input type="checkbox"/> SINGLE	HOW LONG?	_____
<input type="checkbox"/> DIVORCED	<input type="checkbox"/> COHABITATING	PREVIOUS MARRIAGES?	_____
<input type="checkbox"/> SEPARATED	<input type="checkbox"/> WIDOWED	HOW LONG SINCE DIVORCE?	_____

LIST BELOW THE PEOPLE LIVING WITH YOU:

NAME	RELATIONSHIP	AGE	OCCUPATION

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

NAME: _____

ADDRESS: _____

TELEPHONE: _____

RELATIONSHIP TO YOU: _____

Medical History

CURRENT
PHYSICIAN: _____
ADDRESS: _____

CURRENT
MEDICAL
PROBLEMS: _____

MEDICATIONS
BEING
TAKEN: _____

PREVIOUS HOSPITALIZATIONS (MEDICAL OR PSYCHIATRIC)

DATE	HOSPITAL NAME	REASON	LENGTH OF STAY
------	------------------	--------	-------------------

OTHER SERIOUS ILLNESSES

DATE	NATURE OF CONDITION	DURATION
------	---------------------	----------

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

DATE	TYPE OF SERVICES	DESCRIBE PROBLEM	DURATION
------	---------------------	---------------------	----------

Educational and Occupational History

HIGHEST LEVEL OF EDUCATION ATTAINED:

- ☐ ELEMENTARY/MIDDLE SCHOOL: LIST
GRADE _____
- ☐ HIGH SCHOOL: LIST
GRADE _____
- ☐ GED
- ☐ HS DIPLOMA
- ☐ CURRENTLY IN SCHOOL? SCHOOL/LOCATION: _____

- ☐ VOCATIONAL TRAINING: LIST
TRADE _____
- ☐ COLLEGE: LIST
YEARS _____
- ☐ GRADUATE EDUCATION: LIST YEARS OR DEGREE
EARNED _____

CURRENT AND PREVIOUS JOBS:

JOB TITLE EMPLOYER NAME & CITY DATES/DURATION

HOUSEHOLD INCOME:

☐ UNDER \$10,000

☐ \$11,000-30,000

☐ \$31,000-50,000

☐ \$51,000-75,000

☐ OVER \$75,000

OCCUPATION: _____

Family Data

IS FATHER LIVING?

YES ☐

IF YES, CURRENT AGE: _____

RESIDENCE

(CITY):

OCCUPATION:

HOW OFTEN DO YOU HAVE CONTACT?

No ☐

IF NOT LIVING, HIS AGE AT DEATH:

YOUR AGE AT HIS DEATH:

CAUSE OF DEATH:

IS MOTHER LIVING?

YES ☐

IF YES, CURRENT AGE: _____

RESIDENCE

(CITY):

OCCUPATION:

HOW OFTEN DO YOU HAVE CONTACT?

No ☐

IF NOT LIVING, HER AGE AT DEATH:

YOUR AGE AT HER DEATH:

CAUSE OF DEATH:

BROTHERS AND SISTERS

NAME

AGE

OCCUPATION

RESIDENCE

CONTACT HOW OFTEN?

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

NAME

RELATIONSHIP TO YOU

STILL IN CONTACT?

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

	SELF			FAMILY			
	NO- NEVER HAPPENED	UNSURE	YES- THIS HAPPENED	NO- NEVER HAPPENED	UNSURE	YES- THIS HAPPENED	PLEASE INDICATE WHICH FAMILY MEMBER(S)
WHICH OF THE FOLLOWING HAVE FAMILY MEMBERS, <i>INCLUDING YOURSELF</i> , STRUGGLED WITH:							
SEPARATION/DIVORCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FREQUENT RE-LOCATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EXTENDED UNEMPLOYMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ADOPTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FOSTER CARE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
MISCARRIAGE OR FERTILITY DIFFICULTIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FINANCIAL STRAIN OR INSTABILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
INADEQUATE ACCESS TO HEALTHCARE OR OTHER SERVICES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DISCRIMINATION (INSULTS, HATE CRIMES, ETC.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DEATH AND LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ALCOHOL USE OR ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DRUG USE OR ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ADDICTIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
SEXUAL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PHYSICAL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EMOTIONAL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
RAPE/SEXUAL ASSAULT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HOSPITALIZATION FOR MEDICAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HOSPITALIZATION FOR EMOTIONAL/PSYCHIATRIC PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DIAGNOSED OR SUSPECTED MENTAL ILLNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
SUICIDAL THOUGHTS OR ATTEMPTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

SELF HARM (CUTTING, BURNING)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DEBILITATING ILLNESS, INJURY, OR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DISABILITY							_____
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

Client Intake Evaluation Summary

Client: _____ Intake Therapist: _____
Intake Date(s): _____ Date of Report: _____

(Name, age/D.O.B., gender, marital status, # children, occupation/employment status, education, ethnicity, and current living arrangements)

(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
- Revised 9/2014

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 (Follow the outline for "Cultural Formulation" in the DSM-5: Cultural identity, cultural conceptualization of distress, psychosocial

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stressors, and cultural features vulnerability & resilience, cultural features of the relationship between the individual and the clinician, and overall cultural assessment)

(Religious affiliations, strength of commitment to/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 (well, fair, poor/disheveled):

Interpersonal presentation/behavioral observations (friendly, cooperative, guarded):

Orientation (person, place, time, situation):

Speech (pitch, pace, tone):

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

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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 (good, fair, poor):

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

VI. Client Strengths (Intelligence, personality, internal resources, coping skills, support system, talents and abilities, motivation, educational/vocational skills, health)

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

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VIII. DSM-5 Diagnosis

IX. Client Goals (Describe client's own goals for therapy)

Revised 9/2014

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

Intake Therapist

Supervisor

Date

Date

Appendix F
Treatment Summary

TREATMENT SUMMARY

Client's Name: _____

Date: _____

Therapist's Name: _____

Identifying Information:

Treatment Information (*date of initial evaluation, number of sessions, treatment modality [e.g., individual or conjoint], date of transition*):

Course of Treatment (*conceptualization of client's difficulties, therapy orientation, client's response to treatment, emergency/crisis issues. Be sure to connect this with the client's presenting problem, nature of therapeutic relationship, etc.*):

Diagnosis at Termination/Transition/Transfer (for individual clients only):
(*Please, note that the diagnosis at termination needs to reflect the current diagnosis. If the current diagnosis is different from what is on the intake, a "Change of Diagnosis form" MUST BE completed prior to completing the treatment summary.*)

DSM-5 Diagnosis:

Disposition (*state whether the case has been transferred or terminated/transitioned, and give reasons why*):

Check one of the following:

☐ Planned Termination/Transition. If so, check one of the following:

☐ End of treatment

☐ End of treatment at this clinic, client to continue treatment elsewhere

☐ Unplanned Termination/Transition: If so, check one of the following:

☐ Against therapist advice

☐ Lost contact or unable to contact

☐ Transfer within the clinic

Recommendations for Follow-Up (*If the case is being transferred, list specific treatment recommendations for the next therapist, including what worked and did not work with the client(s).*):

Student Therapist

Supervisor

Date

Date

Appendix G
Coding Manual

RESEARCH PROJECT CODING MANUAL

This training manual is intended to describe the methods of transcription and coding that will be utilized for this dissertation research project. The specific therapy session tapes used in the project will be obtained from the Pepperdine Applied Research Center's research database of clients and therapists at Pepperdine University clinics, and selected based on inclusion/exclusion criteria (e.g., individual adult clients of Middle Eastern descent). The researcher will be using this data for her dissertation to understand client emotional regulation in psychotherapy sessions. Research assistants will transcribe videotaped psychotherapy sessions to code for instances of emotional expression identified by the researcher-participant.

This manual contains the following three sections, which describes the sequential steps taken by members of the research team in approaching the coding process:

- I. REVIEW OF EMOTION CONCEPTS
- II. TRANSCRIPTION INSTRUCTIONS
- III. CODING OVERVIEW AND STEPS

I. BACKGROUND INFORMATION ON EMOTION, EMOTION REGULATION, AND EMOTION DYSREGULATION

The first step involves the researcher-participants going through training to develop a shared understanding of the concepts involved in this dissertation. Thus, they will review the following definitions: emotion, emotion regulation, and emotion dysregulation. They will use this information to approach the coding process, which is explained in Step III.

Understanding Emotion

Emotion definition. A concise definition of *emotion* is lacking, due to many unclear definitions and a lack of empirical research based on animal models. Yet, despite the broad range in definitions and approaches, definitions of emotions contain three characteristics that are evident across approaches. First, emotions are said to involve changes in subjective experience, behavior, and physiology (Mauss, Levenson, McCarter, Wilhelm, & Gross, 2005); second, they unfold over time (Cunningham & Zelazo, 2007); and third, they can be adaptive or maladaptive (Gross, 2015a).

Regarding the first characteristic, emotions are affective reactions, either positive or negative, to specific states (Gendolla, 2000; Gross, 2015), which involve psychological, physiological, and behavioral changes. Thus, Russell and Feldman Barrett (1999) referred to emotion as a "complex set of interrelated sub-events concerned with a specific object" (p. 806).

Second, definitions of emotion often describe emotional processes, including how emotions are generated and unfold over time. For example, according to Cozolino and Segal (2009) emotions are at the forefront of perceptual and cognitive processes. Cozolino and Segal (2009) outlined emotion as a primary value system of the brain whereby activations occur in stages. At the first stage, emotion evokes attentional mechanisms on the stimulus. Secondly, appraisal mechanisms assess the hedonic nature of the emotion (e.g., "Am I safe" or "Am I in danger?"). Thirdly, the appraisal method is elaborated further into categorical emotion (e.g.,

happiness, fear, anger, sadness), which generally have universal facial expressions (Cozolino & Segal, 2009). Facial expressions are viewed as emotional responses to a situation, memory, or mental image (Ekman, 1992). Specific facial expressions of emotions are considered universal, which include expressions of hatred, shame, guilt, and interest (Ekman, 1992). At this stage, emotions may also be expressed in other ways, including vocally and behaviorally.

Similarly, a generative process is outlined by Gross, Sheppes, and Urry (2011), in which emotions are generated by an individual during a situation that requires attention, in which the specific situation produces a specific meaning to the individual, and produces a multi-system response to the ongoing person-situation transaction. Akin to Cozolino and Segal's view, this process, according to Gross, is a system where emotions are produced in series of stages: attending to the situation, generating meaning to the situation, and producing experiential, behavioral, and physiological responses (Gross 1998, 2001, 2002).

Third, emotions serve specific functions, which can be adaptive or maladaptive, depending on context (Gross, 2015a). With respect to adaptive functioning, emotions guide our decision-making (Simon, 1967); for example, the experience of fear can prevent us from entering into dangerous situations. Anger can be adaptive in that it can propel individuals into inspiring change and creating social justice. Happiness can foster social interactions, kindle love, and form new interpersonal connections. On the other hand, emotions can be maladaptive when they are used incongruently with a particular situation, or are of the "wrong intensity, duration, and frequency...and maladaptively bias cognition and behavior" (Gross, 2015a, p. 4). Examples include anger that may lead to self-injurious, suicidal, or homicidal behavior and fear that leads to excessive worry, which negatively affects an individual across multiple daily situations.

Understanding emotion regulation. Emotion regulation is a fast growing area within the scientific study of psychology. As a result, several definitions and perspectives of emotion regulation exist, including sociocultural (Matsumoto, Yoo, Nakagawa, 2008) and neurological (Beauregard, Lévesque, & Bourgouin, 2001; Schore, 1994) bases of emotion regulation. Further, models of emotion regulation that focus on early development (Cole, Martin, & Dennis, 2004) as well as adults (Gross, 2015a) exist within the current literature. Because the proposed dissertation study of emotion regulation focuses on the ways in which Middle Eastern adults express emotions, this section focuses on those models that address such action aspects of emotional regulation (e.g., Blackledge & Hayes, 2001, Gross, 2015b, Linehan, 1993).

Gross, a pioneer in the study of emotion regulation, defined emotion regulation as the activation of a goal that recruits one or more processes to influence emotion generation (Gross et al., 2011a, b). It is also loosely referred to the things humans do to influence the emotions they have, when they have them, and how they are experienced and expressed (Gross, 1998). Emotion regulation may be unconscious or conscious (automatic or controlled) utilized to increase, maintain, or decrease one or more components of an emotional response, such as feelings, behaviors, and physiological responses (Gross, 1999; Eftekhari, Zoellner, & Vigil, 2009). An individual's goal to regulate his or her emotions is referred to by Gross (2015) as intrinsic emotion regulation, whereas the goal to regulate others' emotions is referred to as extrinsic emotion regulation. In other words, this regulatory goal either induces a change in the individual experiencing the emotion (intrinsic) or to engender emotional change in another individual (extrinsic) (e.g., a mother soothing her crying child) (Sheppes, Suri, & Gross, 2015; Macklem 2008).

Cultural differences exist regarding the interpersonal effects of emotion regulation based on cultural values (Matsumoto, Yoo, & Nakagawa, 2008). Due to the developmental context of the individual, the ability to regulate emotion, either by regulating the expression of emotion or by inhibiting emotion, is learned (Bell & Calkins, 2000; Miller, McDonough, Rosenblum, & Sameroff, 2002; Volling, McElwain, & Miller, 2002). Emotions, as mentioned earlier, can serve adaptive social functions and can motivate individuals to perform certain behaviors, such as communicating one's internal emotional states and galvanizing others to behave in pro-social ways. Different cultures have distinct set of norms and values relating to emotion regulation, given that emotions serve as primary motivators of behavior, have important social functions, and maintain social order (Keltner et al., 2003; Matsumoto, Yoo, & Nakagawa, 2008).

Of relevance to psychotherapy, *cognitive reappraisal*, a form of cognitive change, refers to how individuals interpret or understand an emotion-stimulating situation to alter its effect on the individual's emotional experience. Additionally, *suppression*, a form of response modulation, is referred to as the inhibition of emotional experience or emotionally expressive behavior (Gross, 1998; Gross & John, 2003). Matsumoto, Yoo, and Nakagawa (2008) proposed that differences in values orientations are associated with differences in emotion-regulation norms. Specifically, they suggested that cultures that value *Individualism*, *Egalitarianism*, and *Affective Autonomy*, utilize Reappraisal and less Suppression of emotional experience, given the value placed on emotion and emotional expression (Matsumoto, Yoo, & Nakagawa, 2008). Cultures emphasizing *Power Distance*, *Embeddedness*, and *Hierarchy*, utilize less Reappraisal and have a tendency to value Suppression, given the decreased emphasis on emotions and the necessity to suppress emotions for the greater good of the family unit or the community (Matsumoto, Yoo, & Nakagawa, 2008). Middle-Eastern cultures typically value *Power Distance*, *Embeddedness*, and *Hierarchy*; thus, this study aims to include ways in which Middle Eastern individuals may suppress or reappraise their emotions during the process of psychotherapy.

Emotion Regulation Measures. Of the emotion regulation measures highlighted in the proposed study that may assist coders in understanding how to assess this construct, three are shared here. First, the *Trait Meta-Mood Scale* (TMMS) assesses "individual differences in the ability to reflect upon and manage one's emotions" (Salovey et al., 1995, p. 126).

Second, the *Emotion Regulation Questionnaire* (ERQ; Gross & John, 2003) is a 10-item self-report instrument that assesses emotion regulation, utilizing two subscales measuring cognitive reappraisal and suppression.

The third measure also links emotional avoidance with emotional regulation, assuming that all emotion regulation strategies are adaptive regardless of context (Gratz & Roemer, 2004). The *Negative Mood Regulation Scale* (NMR), a 30-item self-report instrument of emotion regulation, specifically measures the beliefs that a "behavior or cognition will alleviate a negative state or induce a positive one" (Catanzaro & Mearns, 1990, p. 547). In other words, it has been described an adequate measure that assesses a person's access to emotion regulation *perceived* as effective (Gratz & Roemer, 2004).

The NMR emphasizes how one attempts to avoid negative emotions rather than modulate his/her behaviors while confronted with negative emotions. But the NMR does not assess important aspects of emotion regulation, including awareness, understanding, and acceptance of emotions.

Understanding Emotion Dysregulation

Of the different approaches to studying emotion dysregulation, emotion dysregulation can be understood as a process involving multiple components and not as a distinct mental state (Werner & Gross, 2010). The components of emotion dysregulation can be viewed as: emotional vulnerability (made up of emotion sensitivity and heightened and labile negative affect) and lack of skills to regulate emotions (made up of a deficit of appropriate regulation strategies, and a surplus of maladaptive regulation strategies) (Carpenter & Trull, 2013; Linehan, 1993). Although presented in the context of BPD, Linehan's description of emotional dysregulation can be applied to broader populations. In her model, individuals with high sensitivity to emotion stimuli have a limited capacity or threshold for emotions and experience a quick reaction to negative emotional cues (Linehan, 1993). Another aspect of emotion vulnerability is emotional intensity, which simply refers to an intense reaction to emotion-provoking situations or stimuli that disrupts cognition and the ability to self-regulate (Linehan, 1993). A third aspect of emotion vulnerability is slow return to baseline, which refers to long-lasting intense emotional reactions that focus the individual's attention to negative aspects of their environment that ultimately maintain their current negative mood (Linehan, 1993). Thus, individuals who face difficulty regulating their emotions, especially individuals with BPD, typically experience intense and labile affect. Often, difficulties regulating or controlling their emotions are based on self-deprecation of experiencing their emotions; thus, according to Linehan, affect regulation must first be paired with emotional self-regulation (Linehan, 1993).

Emotion Dysregulation Measures. The measures of emotion dysregulation highlighted in the proposed study include the *Difficulties in Emotion Regulation Scale*, and the *Acceptance and Action Questionnaire*. In an effort to narrow the gap in the literature and clinical utility of assessment of emotion dysregulation, the *Difficulties in Emotion Regulation Scale* (DERS; Gratz & Roemer, 2004) was developed to provide a more comprehensive clinical assessment of emotion dysregulation. According to Gratz and Roemer (2003), "items on the DERS capture difficulties within the following dimensions of emotion regulation: (a) awareness and understanding of emotions; (b) acceptance of emotions; (c) the ability to engage in goal-directed behavior, and refrain from impulsive behavior, when experiencing negative emotions; and (d) access to emotion regulation strategies perceived as effective" (p. 43). The DERS also includes a final dimension to measure flexibility in the use of appropriate modulation of emotional responses (Gratz & Roemer, 2004).

The *Acceptance and Action Questionnaire - II* (AAQ-II) aims to measure experiential avoidance (i.e., the avoidance of inner experiences such as unwanted emotions and thoughts) (Bond et al., 2011). The AAQ-II is a ten-item, self-report measure that assess experiential avoidance and control, negative evaluations of internal experience, presence or lack of psychological acceptance, and the extent to which an individual behaves regardless of distress or how the distress affects behavioral avoidance (Bond et al., 2011).

II. Transcription Instructions

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

Research assistants will transcribe verbatim each therapy session to be included in the research to provide a format for more in-depth analysis of therapist and/or client statements to then be

coded. Attached at the end of this section is a template that will be use for transcriptions. After reading this manual and discussing questions during training, RAs will be asked to practice transcribing an excerpt from a Motivational Interviewing tape by William Miller. At the end of the practice, we will review with you a completed transcript to check your work and address any questions.

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

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

In addition to capturing the actual words, speech patterns and thought patterns of the speakers, we would like to try and capture some of the more important non-verbal behaviors/communication taking place between the therapist and client. In order to do so, please use parentheses with numbers inside of them to indicate pauses in a speaker's response. For example, use (3) to represent a three second pause or (10) for a ten second pause. Use this whenever there are significant pauses or moments of silence between the speakers.

When attempting to capture non-verbal behaviors/movements that are significant to the therapeutic interaction taking place, use brackets [] to indicate these movements and clearly state which person—the therapist or client—is performing the movement and what specifically he/she does. For example, [Client turned away from the therapist and looked down at the ground] or [Client laughs] or [Therapist sighed deeply and looked away briefly]. Only note hand gestures that have meaning. For example, the therapist gestures toward her heart when asking about how the client feels, or gestures hands toward self when asking client to say more. Do not note hand gestures that do not carry meaning, such as simply moving hands in the air while talking. Also use brackets to indicate the inability to hear/understand a word or sentence: [Unintelligible] or [Inaudible]. Please make every effort to hear and understand what is said. Sometimes you can figure out a word by the context of what the speaker is saying. If you can make an educated guess, type the closest possible approximation of what you hear, underline the questionable portion, and add 2 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 2 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 2 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

Session Number: 1

Client: Ms. S

Date of Session: xx/xx/xxxx

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

T = Therapist; C = Client

Verbatim Transcript of Session	Initial Coding Impressions
[Content Removed for dissertation publication]	

III. Coding Overview and Steps

The third step of the process involves the researcher-participant engaging in the inductive coding process, which in this study involves open coding. An inductive approach attempts to explore themes and categories that emerge from the observance of data (Hsieh & Shannon, 2005). By undertaking the inductive approach, the researcher withholds the imposition of preexisting knowledge in order to observe and learn new information that may provide additional useful data to existing literature (Schilling, 2006), in this case regarding instances of emotion regulation among Middle Eastern individuals in psychotherapy. In particular, a conventional content analysis approach will be utilized to observe themes that emerge from the gathered data in order to further classify the observable phenomena (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005; Weber, 1990). The content analysis approach is significantly useful when current research may be scarce or segmented (Elo & Kyngäs, 2008), as seen in the current state of research regarding emotion regulation among Middle Eastern Americans.

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.

Procedures for Identifying Themes of Emotion and Emotion Regulation

The target person that will be coded is the client-participant. The unit of coding is a client's talk turn. Themes will emerge from words, phrases, or sentences describing emotion regulation. Themes may be observed within one session, across multiple sessions with the same psychotherapy client, and/or gathered across multiple sessions with multiple clients.

The researcher begins this process by examining the data and noting themes that emerge naturally from their process of reviewing the session recording and transcripts. 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 or she feels he or she has captured all of the relevant themes.

InVivo Coding. Researches will code the data utilizing the InVivo Coding method, also understood as "literal coding" and "verbatim coding," as this method utilizes the participants'

language verbatim (Saldaña, 2009). As this study seeks to examine how Middle Eastern Americans in psychotherapy regulate emotions, the InVivo Coding approach allows the researchers to code the participants' actual words in order to preserve the participants' voices, as well as to understand his or her world views and cultures (Saldaña, 2009). This approach is helpful to capture specific nuances and cultural metaphors, as well as specific behaviors that illuminate how client participants regulate emotions in sessions (Saldaña, 2009). InVivo coding provides a useful tool to qualitatively review the participant's nuanced communication.

Emotion Coding. Researchers will code specific emotions identified, recalled, or experienced by the client participant in a process named Emotion Coding (Saldaña, 2009). Emotion Coding also allows the researchers to infer specific emotions experienced by the participant (Saldaña, 2009).

Emotion Regulation Coding. This third, yet related, approach to the Emotion Coding process, allows researchers to explore and identify how clients engage in emotional suppression, avoidance, impression management, and emotional denial (Saldaña, 2009). Given that the study seeks to identify how Middle Eastern psychotherapy clients regulate emotions in session, Emotion Regulation Coding enables researchers to identify the subjective emotional experiences of the participant (Saldaña, 2009).

Themes relevant to emotional regulation may include instances where clients directly identify their emotion and verbally expresses it (e.g. "I feel sad"), when clients appears to reflect on their emotions (e.g., "I'm usually very clear about my feelings"; "I was able to stop and notice that I was feeling sad"), and manage their emotions (e.g., "I try to take a deep breath to manage my anger"; "I need help dealing with my feelings"; "I was feeling kind of anxious, so I didn't feel like going out this week"). Themes of emotional regulation may also include ways in which clients reappraise their cognitions (e.g., "I control my emotions by changing the way I think about the situation I'm in," and "When I want to feel less sad I change what I'm thinking about"). Further, emotional regulation may also be exhibited in therapy by the client's verbalizations of how he or she suppresses his/her emotions (e.g., "When I am feeling negative emotions, I make sure not to express them," "I control my emotions by not expressing them"; "I needed to take a time out and walk away, as I was just getting too pissed off").

Regarding emotional dysregulation, themes may come from observations of clients having difficulty identifying or expressing their feelings (e.g., "I don't know what I am feeling" and "I am confused about how I feel"). Emotion dysregulation can also be understood as experiential avoidance (i.e., the avoidance of inner experiences such as unwanted emotions and thoughts) and/or control ("e.g., it's not ok if I get angry with others;" "I have to stop feeling so anxious and overwhelmed") (Bond et al., 2011). Similarly, negative evaluations of internal experiences and distress may affect their abilities to manage their emotion (e.g., "I'm afraid of my feelings," "Emotions cause problems in my life," and "It's not OK if I remember something unpleasant."). Difficulties modulating emotions in session can also indicate emotion dysregulation, such as intense and labile affect expressed with a loud tone and volume and aggressive movements.

In addition, the following techniques will be used to identify themes: analyzing repetitions, the use of metaphors and analogies, and transitions in process (Ryan & Bernard, 2003).

Examples of Open Coding Techniques to Identify Themes During Open Coding (Ryan & Bernard, 2003)

Codes	Examples	Comments
Repetitions	<p>C1: It made me upset when she left without saying goodbye.</p> <p>C2: I felt hurt by her actions.</p>	These can be referred to as concepts that frequently occur within the text.
Metaphors and Analogies	<p>C1: My heart felt heavy (expression of fear).</p> <p>C2: I am living a dark life (conveying depression).</p>	This can be the client's use of symbolic imagery to explain schematically relevant thoughts, behaviors, and beliefs.
Transitions in process	C1: When you asked me if I was upset with you, it reminded me of when I became upset with my brother this past week.	These can be observed as naturally occurring shifts or changes in speech. The client may change the topic, pause their speech, change their tone of voice, or other verbal or non-verbal behaviors.

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.

Creating Categories. 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.

Abstraction. 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 video sessions and read the entire transcript to ensure accuracy. Familiarize yourself with the content and processes 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. Be familiar with the open coding steps of (a) identifying themes, (b) creating categories, and (c) abstraction. Then, begin the coding process, simultaneously reading the written session transcriptions and watching the corresponding session videotape. Approach the data by coding for InVivo, Emotion, and Emotion Regulation.
4. Individually, read the transcript again in detail by looking at each statement (C1, C2, etc.) and write your coding impressions on the right hand column of the transcript sheet.
5. Meet with team of coders to discuss themes and categories to 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 have been appropriately 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 an Excel data-tracking sheet for further analysis.

APPENDIX H

Emotion Codes and Definitions

Anger: a strong feeling of annoyance, displeasure, or hostility

anger, aggravation, agitation, annoyance, bitterness, exasperation, ferocity, frustration, fury, grouchiness, grumpiness, hostility, indignation, irritation, outrage, rage, vengefulness, wrath, upset

Disgust: a feeling of revulsion or profound disapproval aroused by something unpleasant or offensive

disgust, abhorrence, antipathy, aversion, condescension, contempt, dislike, derision, disdain, distaste, hate, loathing, repugnance, repelled, repulsion, resentment, revolted, scorn, sickened, spite, vile

Envy: a feeling of discontented or resentful longing aroused by someone else's possessions, qualities, or luck

Envy, bitterness, covetous, craving, discontented, disgruntled, displeased, dissatisfied, down-hearted, greed, "green-eyed", longing, pettiness, resentment, wishful

Fear: an unpleasant emotion caused by the belief that someone or something is dangerous, likely to cause pain, or a threat; a mixed feeling of dread and reverence; a feeling of anxiety concerning the outcome of something or the safety and well-being of someone; the likelihood of something unwelcome happening

Fear, anxiety, apprehension, dread, edginess, fright, horror, hysteria, jumpiness, nervousness, overwhelmed, panic, shock, tenseness, terror, uneasiness, worry

Guilt: the fact of having committed a specified or implied offense or crime; a feeling of having done wrong or failed in an obligation

Guilt, culpability, remorse, apologetic, regret, sorry

Happy: feeling or showing pleasure or contentment

Happy, happiness, joy, enjoyment, relief, amusement, enthrallment, hope, satisfaction, bliss, enthusiasm, jolliness, thrill, cheerfulness, euphoria, joviality, triumph, contentment, excitement, jubilation, zaniness, delight, exhilaration, optimism, zest, eagerness, gaiety, pleasure, zeal, ecstasy, gladness, pride, elation, glee, rapture

Jealous: feeling or showing envy of someone or their achievements and advantages; feeling or showing suspicion of someone's unfaithfulness in a relationship; fiercely protective or vigilant of one's rights or possessions

Jealous, cautious, clinging, clutching, defensive, mistrustful, fear of losing someone/something, possessive, rivalrous, suspicious, self-protective, wary, watchful

Love: an intense feeling of deep affection

Love, adoration, affection, arousal, attraction, caring, charmed, compassion, desire, enchantment, fondness, infatuation, kindness, liking, limerence, longing, lust, passion, sentimentality, sympathy, tenderness, warmth

Pride: a feeling of deep pleasure or satisfaction derived from one's own achievements, the achievements of those with whom one is closely associated, or from qualities or possessions that are widely admired

Sad: feeling or showing sorrow; unhappy

Sad, despair, grief, misery, agony, disappointment, homesickness, neglect, alienation, discontentment, pity, anguish, dismay, hurt, rejection, crushed, displeasure, insecurity, sorrow, defeat, distraught, disconnected, suffering, dejection, gloom, loneliness, unhappiness, depression, glumness, melancholy, alone, woe

Shame: a painful feeling of humiliation or distress caused by the consciousness of wrong or foolish behavior; a person, action, or situation that brings a loss of respect or honor

Shame, contrition, culpability, discomposure, embarrassment, humiliation, mortification, self-conscious, shyness

Surprise: an unexpected or astonishing event, fact, or thing; a feeling of mild astonishment or shock caused by something unexpected

Stressed: Stress can be external and related to the environment, but may also be created by internal perceptions that cause an individual to experience anxiety or other negative emotions surrounding a situation, such as pressure, discomfort, etc., which they then deem stressful.

Pressured

Discomfort: a state of mental unease; worry or embarrassment

Concern: anxiety; worry; a cause of anxiety or worry

Care: feel concern or interest; attach importance to something

Hopeful - feeling or inspiring optimism about a future event.

¹*Emotion words sampled from Linehan Skills Manual (Linehan, 2015)*

APPENDIX I

Emotion Regulation Parent Themes & Categories Codes and Definitions

Emotion Dysregulation: use of maladaptive regulation strategies, lower emotional awareness, and/or the inability to inhibit or regulate distressing emotions

Experiential Avoidance: avoid thoughts, feelings, inner emotional experiences, physical sensations, and/or memories, and/or engaged in behaviors to avoid these specific situations and contexts

Negative Emotional Reactivity: heightened adverse emotional response to environmental or internal stimuli.

Difficulty Labeling Current Affect: difficulty with identifying, labeling, distinguishing, and expressing emotions

Emotion Regulation: It was defined as how the client manages his/her emotions by flexibly and adaptively responding to negative emotional experiences.

Acceptance: acknowledgement of emotional, situational, or environmental difficulties without attempting to escape or avoid the respective situations

Increasing Positive Emotional Events: utilization of positive coping to facilitate emotional regulation.

Labeling Current Affect: The *Labeling Current Affect* category was described as the ability to identify and express emotions experienced in the current moment.

APPENDIX J

Emotion Regulation/Dysregulation Frequency Codes

CP1		CP2		CP3		TOTALS ACROSS CPS
EMOTION DYSREGULATION	Total	EMOTION DYSREGULATION		EMOTION DYSREGULATION		
experiential avoidance #0	8	experiential avoidance #1	5	experiential avoidance #1	7	20
experiential avoidance #1	9	experiential avoidance #8	7	experiential avoidance #51	8	24
experiential avoidance #2	30	experiential avoidance #16	3	experiential avoidance #110	5	38
experiential avoidance TOTAL	47	experiential avoidance TOTAL	15	experiential avoidance TOTAL	20	82
negative emotional reactivity #0	0	negative emotional reactivity #1	5	negative emotional reactivity #1	0	5
negative emotional reactivity #1	9	negative emotional reactivity #8	1	negative emotional reactivity #51	2	12
negative emotional reactivity #2	2	negative emotional reactivity #16	0	negative emotional reactivity #110	0	2
negative emotional reactivity TOTAL	11	negative emotional reactivity TOTAL	6	negative emotional reactivity TOTAL	2	19
difficulty labeling current affect #0	1	difficulty labeling current affect #1	2	difficulty labeling current affect #1	1	4
difficulty labeling current affect #1	1	difficulty labeling current affect #8	0	difficulty labeling current affect #51	3	4
difficulty labeling current affect #1	0	difficulty labeling current affect #16	0	difficulty labeling current affect #110	0	0
difficulty labeling current affect TOTAL	2	difficulty labeling current affect TOTAL	2	difficulty labeling current affect TOTAL	4	8
CP1		CP2		CP3		
EMOTION REGULATION	Total	EMOTION REGULATION		EMOTION REGULATION		
acceptance #0	1	acceptance #1	2	acceptance #1	1	4
acceptance #1	1	acceptance #8	0	acceptance #51	0	1
acceptance #2	0	acceptance #16	3	acceptance #110	4	7
acceptance TOTAL	2	acceptance TOTAL	5	acceptance TOTAL	5	12
increasing positive emotional events #0	0	increasing positive emotional events #1	0	increasing positive emotional events #1	1	1
increasing positive emotional events #1	1	increasing positive emotional events #8	3	increasing positive emotional events #51	0	4
increasing positive emotional events #2	0	increasing positive emotional events #16	0	increasing positive emotional events #110	1	1

increasing positive emotional events TOTAL	1	increasing positive emotional events TOTAL	3	increasing positive emotional events TOTAL	2	6
labeling current affect #0	4	labeling current affect #1	1	labeling current affect #1	1	6
labeling current affect #1	0	labeling current affect #8	1	labeling current affect #51	8	9
labeling current affect #2	2	labeling current affect #16	0	labeling current affect #110	0	2
labeling current affect TOTAL	6	labeling current affect TOTAL	2	labeling current affect TOTAL	9	17

APPENDIX K

Emotion Codes Frequency

CP1

Session #0	Subtotal	Session #1	Subtotal	Session #2	Subtotal	Total
Anger inferred	19	Anger inferred	15	Anger inferred	20	54
Anger expressed	13	Anger expressed	6	Anger expressed	6	25
TOTAL anger	32	TOTAL anger	21	TOTAL anger	26	79
Happy Inferred	7	Happy Inferred	2	Happy Inferred	0	9
Happy Expressed	0	Happy Expressed	0	Happy Expressed	0	0
TOTAL Happy	7	TOTAL Happy	2	TOTAL Happy	0	9
Pride Inferred	1	Pride Inferred	0	Pride Inferred	0	1
Pride Expressed	1	Pride Expressed	0	Pride Expressed	0	1
TOTAL Pride	2	TOTAL Pride	0	TOTAL Pride	0	2
Love inferred	0	Love inferred	2	Love inferred	0	2
Love expressed	2	Love expressed	0	Love expressed	0	2
TOTAL Love	2	TOTAL Love	2	TOTAL Love	0	4
Discomfort inferred	1	Discomfort inferred	0	Discomfort inferred	3	4
Discomfort expressed	0	Discomfort expressed	0	Discomfort expressed	0	0
TOTAL Discomfort	1	TOTAL Discomfort	0	TOTAL Discomfort	3	4
Surprise inferred	0	Surprise inferred	2	Surprise inferred	1	3
Surprise expressed	0	Surprise expressed	0	Surprise expressed	0	0
TOTAL Surprise	0	TOTAL Surprise	2	TOTAL Surprise	1	3
Fear inferred	8	Fear inferred	16	Fear inferred	4	28
Fear expressed	2	Fear expressed	2	Fear expressed	3	7
TOTAL Fear	10	TOTAL Fear	18	TOTAL Fear	7	35
Sad inferred	0	Sad inferred	4	Sad inferred	1	5
Sad expressed	1	Sad expressed	0	Sad expressed	0	1
TOTAL Sad	1	TOTAL Sad	4	TOTAL Sad	1	6
Shame inferred	2	Shame inferred	5	Shame inferred	3	10
Shame expressed	5	Shame expressed	0	Shame expressed	0	5
TOTAL Shame	7	TOTAL Shame	5	TOTAL Shame	3	15
Stress inferred	3	Stress inferred	6	Stress inferred	3	12
Stress expressed	0	Stress expressed	5	Stress expressed	0	5
TOTAL Stress	3	TOTAL Stress	11	TOTAL Stress	3	17
Guilt inferred	0	Guilt inferred	1	Guilt inferred	3	4
Guilt expressed	0	Guilt expressed	1	Guilt expressed	0	1
TOTAL Guilt	0	TOTAL Guilt	2	TOTAL Guilt	3	5
Positive inferred	8	Positive inferred	4	Positive inferred	0	12
Positive expressed	3	Positive expressed	0	Positive expressed	0	3
TOTAL positive	11	TOTAL positive	4	TOTAL positive	0	15
Negative inferred	33	Negative inferred	47	Negative inferred	37	117
Negative expressed	21	Negative expressed	14	Negative expressed	9	44
TOTAL negative	54	TOTAL negative	61	TOTAL negative	46	161

CP2

Session #0	Subtotal	Session #8	Subtotal	Session #16	Subtotal	Total
Anger inferred	8	Anger inferred	5	Anger inferred	0	13
Anger expressed	7	Anger expressed	4	Anger expressed	0	11
TOTAL anger	15	TOTAL anger	9	TOTAL anger	0	24
Happy Inferred	1	Happy Inferred	1	Happy Inferred	8	10
Happy Expressed	0	Happy Expressed	2	Happy Expressed	1	3
TOTAL Happy	1	TOTAL Happy	3	TOTAL Happy	9	13
Pride Inferred	0	Pride Inferred	0	Pride Inferred	0	0
Pride Expressed	0	Pride Expressed	0	Pride Expressed	0	0
TOTAL Pride	0	TOTAL Pride	0	TOTAL Pride	0	0
Love inferred	0	Love inferred	0	Love inferred	0	0
Love expressed	0	Love expressed	0	Love expressed	0	0
TOTAL Love	0	TOTAL Love	0	TOTAL Love	0	0
Discomfort inferred	1	Discomfort inferred	0	Discomfort inferred	0	1
Discomfort expressed	0	Discomfort expressed	0	Discomfort expressed	0	0
TOTAL Discomfort	1	TOTAL Discomfort	0	TOTAL Discomfort	0	1
Surprise inferred	0	Surprise inferred	0	Surprise inferred	0	0
Surprise expressed	0	Surprise expressed	0	Surprise expressed	2	2
TOTAL Surprise	0	TOTAL Surprise	0	TOTAL Surprise	2	2
Fear inferred	4	Fear inferred	0	Fear inferred	2	6
Fear expressed	2	Fear expressed	1	Fear expressed	4	7
TOTAL Fear	6	TOTAL Fear	1	TOTAL Fear	6	13
Sad inferred	3	Sad inferred	7	Sad inferred	0	10
Sad expressed	0	Sad expressed	5	Sad expressed	0	5
TOTAL Sad	3	TOTAL Sad	12	TOTAL Sad	0	15
Shame inferred	2	Shame inferred	1	Shame inferred	0	3
Shame expressed	3	Shame expressed	0	Shame expressed	0	3
TOTAL Shame	5	TOTAL Shame	1	TOTAL Shame	0	6
Stress inferred	3	Stress inferred	4	Stress inferred	0	7
Stress expressed	1	Stress expressed	6	Stress expressed	0	7
TOTAL Stress	4	TOTAL Stress	10	TOTAL Stress	0	14
Guilt inferred	1	Guilt inferred	2	Guilt inferred	0	3
Guilt expressed	0	Guilt expressed	0	Guilt expressed	0	0

TOTAL Guilt	1	TOTAL Guilt	2	TOTAL Guilt	0	3
Positive inferred	1	Positive inferred	1	Positive inferred	8	10
Positive expressed	0	Positive expressed	2	Positive expressed	1	3
TOTAL positive	1	TOTAL positive	3	TOTAL positive	9	13
Negative inferred	22	Negative inferred	19	Negative inferred	2	43
Negative expressed	13	Negative expressed	16	Negative expressed	4	33
TOTAL negative	35	TOTAL negative	35	TOTAL negative	6	76

CP3

Session #1	Subtotal	Session #51	Subtotal	Session #110	Subtotal	Total
Anger inferred	2	Anger inferred	7	Anger inferred	0	9
Anger expressed	4	Anger expressed	11	Anger expressed	1	16
TOTAL anger	6	TOTAL anger	18	TOTAL anger	1	25
Happy Inferred	0	Happy Inferred	0	Happy Inferred	3	3
Happy Expressed	3	Happy Expressed	0	Happy Expressed	1	4
TOTAL Happy	3	TOTAL Happy	0	TOTAL Happy	4	7
Pride Inferred	0	Pride Inferred	0	Pride Inferred	0	0
Pride Expressed	0	Pride Expressed	0	Pride Expressed	0	0
TOTAL Pride	0	TOTAL Pride	0	TOTAL Pride	0	0
Love inferred	0	Love inferred	0	Love inferred	0	0
Love expressed	0	Love expressed	0	Love expressed	0	0
TOTAL Love	0	TOTAL Love	0	TOTAL Love	0	0
Discomfort inferred	0	Discomfort inferred	1	Discomfort inferred	0	1
Discomfort expressed	2	Discomfort expressed	1	Discomfort expressed	0	3
TOTAL Discomfort	2	TOTAL Discomfort	2	TOTAL Discomfort	0	4
Surprise inferred	0	Surprise inferred	0	Surprise inferred	0	0
Surprise expressed	0	Surprise expressed	0	Surprise expressed	0	0
TOTAL Surprise	0	TOTAL Surprise	0	TOTAL Surprise	0	0
Fear inferred	3	Fear inferred	4	Fear inferred	5	12
Fear expressed	7	Fear expressed	11	Fear expressed	3	21
TOTAL Fear	10	TOTAL Fear	15	TOTAL Fear	8	33
Sad inferred	2	Sad inferred	7	Sad inferred	0	9

Sad expressed	1	Sad expressed	4	Sad expressed	0	5
TOTAL Sad	3	TOTAL Sad	11	TOTAL Sad	0	14
Shame inferred	3	Shame inferred	5	Shame inferred	6	14
Shame expressed	3	Shame expressed	4	Shame expressed	0	7
TOTAL Shame	6	TOTAL Shame	9	TOTAL Shame	6	21
Stress inferred	0	Stress inferred	0	Stress inferred	0	0
Stress expressed	1	Stress expressed	6	Stress expressed	0	7
TOTAL Stress	1	TOTAL Stress	6	TOTAL Stress	0	7
Guilt inferred	1	Guilt inferred	1	Guilt inferred	0	2
Guilt expressed	3	Guilt expressed	3	Guilt expressed	0	6
TOTAL Guilt	4	TOTAL Guilt	4	TOTAL Guilt	0	8
Hopeful inferred	1	Hopeful inferred	0	Hopeful inferred	0	1
Hopeful expressed	0	Hopeful expressed	0	Hopeful expressed	0	0
TOTAL hopeful	1	TOTAL hopeful	0	TOTAL hopeful	0	1
Positive inferred	1	Positive inferred	0	Positive inferred	3	4
Positive expressed	3	Positive expressed	0	Positive expressed	1	4
TOTAL positive	4	TOTAL positive	0	TOTAL positive	4	8
Negative inferred	11	Negative inferred	25	Negative inferred	11	47
Negative expressed	21	Negative expressed	40	Negative expressed	4	65
TOTAL negative	32	TOTAL negative	65	TOTAL negative	15	112

APPENDIX L

Coding Document Shell

Transcript	Emotion Regulation Codes	Emotion Regulation Notes	In-vivo Codes	Emotion Codes	Researcher Notes	Auditor Notes	Discussion Areas/Decision Points

APPENDIX M

Audit Trail Shell

		<i>Include and describe decisions that were made regarding the research design, data collection, analysis, and reporting as well as personal reflections and biases</i>		
Date	Writer	Note	Auditor notes	Response to Auditor Notes

Appendix N
IRB Certificate

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Jennifer Nehme** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 06/06/2016.

Certification Number: 2089631.

Appendix O

HIPAA Certificate



Certificate of Completion

THIS CERTIFIES THAT

Jennifer Nehme

completed the following course:

HIPAA Basics

1.5 hrs

06-23-15

Pepperdine University

AWARDED BY

LawRoom
Inspired Employer Solutions

APPENDIX P

Client Participant Demographic Information

Table P1

CP	Age	Gender	Ethnicity	Religion	Diagnoses at Intake	Diagnoses at Termination
1	25	Male	Iranian	Muslim & Catholic	Axis I: Partner Relational Problem Axis II: V71.09 No Diagnosis Axis III: none (per client report) Axis IV: stressful career, difficulties with mother Axis V: 76 (current)	N/A ¹
2	32	Female	Iranian & Romanian	Jewish	Axis I: 311 Depressive Disorder Not Otherwise Specified V61.20 Parent-Child Relational Problem V61.8 Sibling Relational Problem Axis II: 799.9 Diagnosis Deferred Axis III: None (per client report) Axis IV: Occupational Problems (viz., conflict with co-workers) Axis V: GAF = 70 (current)	Axis I: 311 Depressive Disorder Not Otherwise Specified V61.20 Parent-Child Relational Problem V61.8 Sibling Relational Problem Axis II: 799.9 Diagnosis Deferred Axis III: None (per client report) Axis IV: Occupational Problems (viz., conflict with co-workers) Axis V: GAF = 77 (current)
3	36	Male	Iranian & Israeli	Jewish	300.4 (F34.1) Persistent Depressive Disorder with Anxious Distress 300.23 (F40.10) Social Anxiety Disorder (Social Phobia) 301.82 (F60.6) Avoidant Personality Disorder (Provisional) 315.35 (F80.81) Childhood-Onset Fluency Disorder (Stuttering)	300.23 (F40.10) Social Anxiety Disorder (Social Phobia) 300.4 (F34.1) Persistent Depressive Disorder with Anxious Distress, in Partial Remission, Mild Severity 315.35 (F80.81) Childhood-Onset Fluency Disorder (Stuttering)

Note. ¹Diagnoses unknown due to CP1's premature termination

APPENDIX Q

Client-Participants and Session Numbers Included for Analysis

Table Q1

Client-Participant	Beginning Session Number	Middle Session Number	End-of-Treatment Session Number	Total Sessions
1	0	1	2	3
2	1	8	16	17
2	1	51	110	112

APPENDIX R

Parent Themes and Corresponding Categories Across Client-Participants

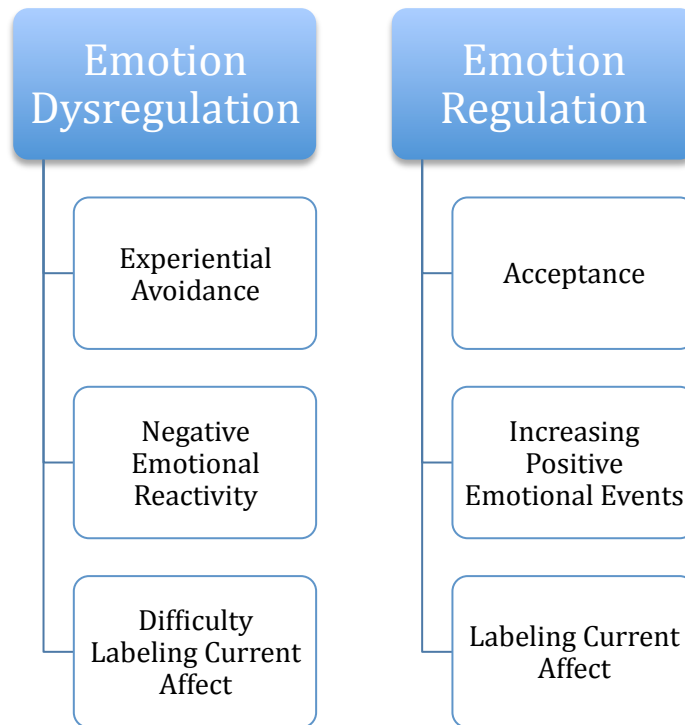


Figure R1. Parent Themes and corresponding categories across client-participants

APPENDIX S

Total Emotion Dysregulation Codes Across Client-Participants

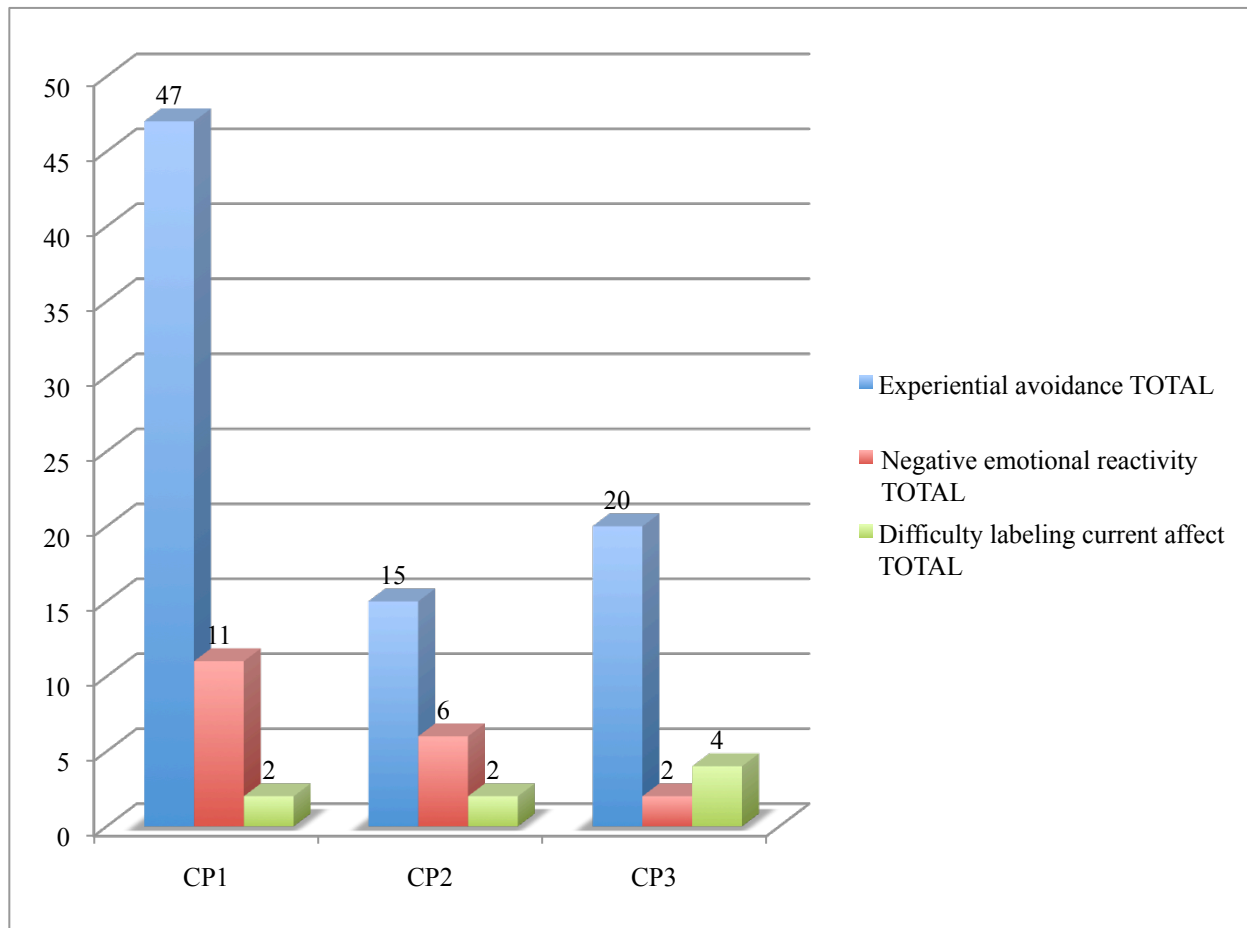


Figure S1. Total emotion dysregulation codes across client-participants

APPENDIX T

Total Emotion Regulation Codes Across Client-Participants

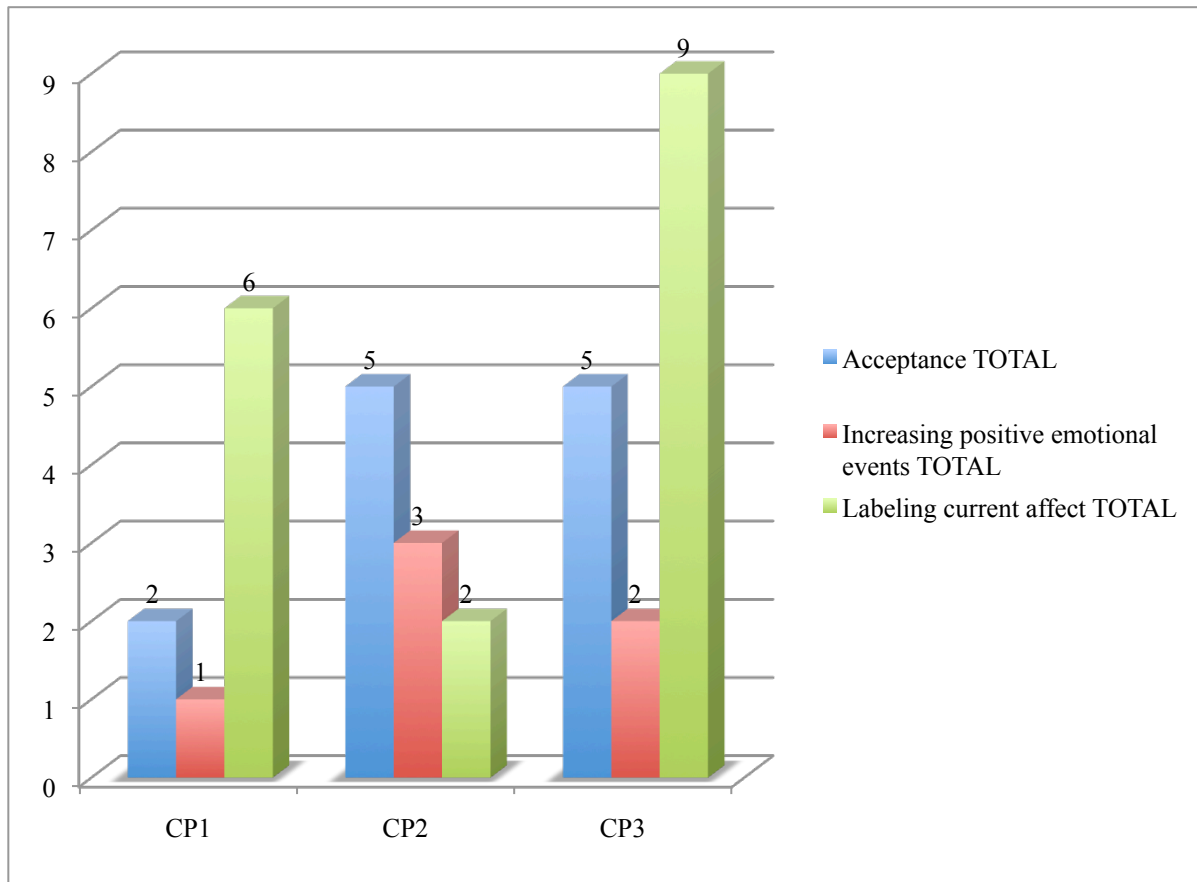


Figure T1. Total emotion regulation codes across client-participants

APPENDIX U

Total Positive and Negative Emotion Codes Across Client-Participants

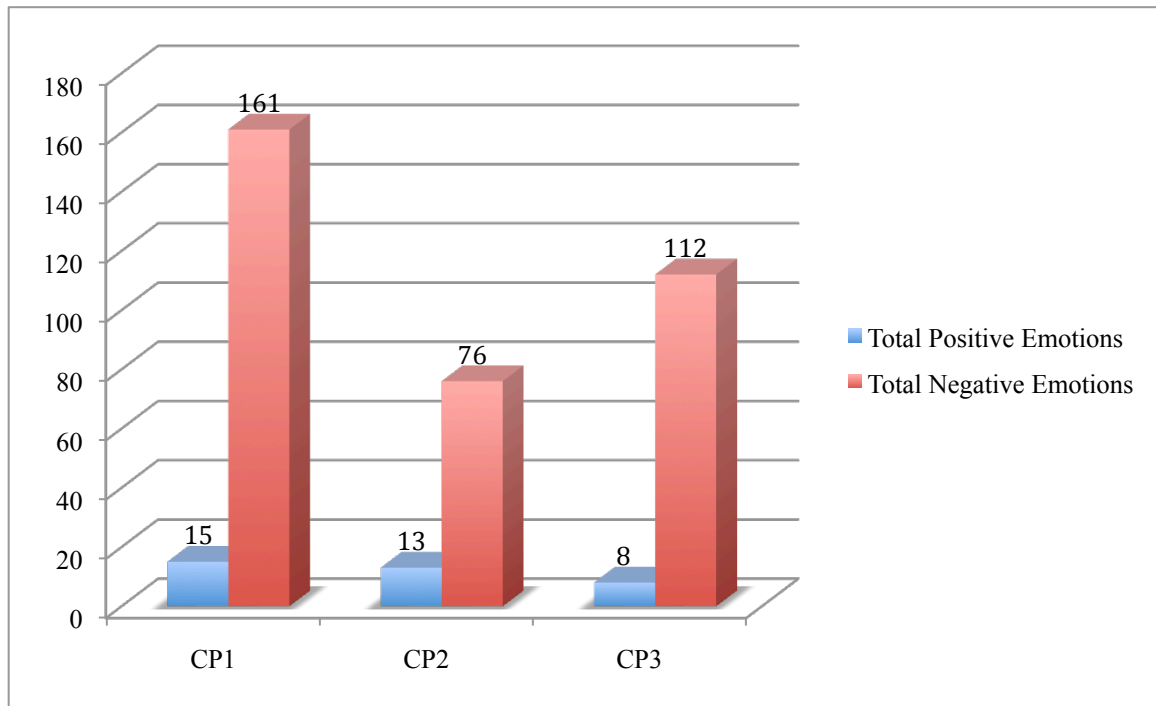


Figure U1. Total positive and negative emotion codes across client-participants

APPENDIX V

Institutional Review Board Letter of Approval



Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: August 18, 2016

Protocol Investigator Name: Jennifer Nehme

Protocol #: 16-06-316

Project Title: Qualitative Analysis of Emotion Regulation as seen in Middle Eastern Psychotherapy clients

School: Graduate School of Education and Psychology

Dear Jennifer Nehme:

Thank you for submitting your application for expedited review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your 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 of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

Based upon review, your IRB application has been approved. The IRB approval begins today August 18, 2016, and expires on August 17, 2017.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. You can only use copies of the consent that have been stamped with the IRB expiration date to obtain consent from your participants.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and will require a submission of a new IRB application or other materials to the IRB. If contact with subjects will extend beyond August 17, 2017, a continuing review 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 the 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 IRB as soon as possible. We will ask for a complete written explanation of the event and your written 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 IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Page: 1



Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

Judy Ho, Ph.D., IRB Chairperson

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives

Mr. Brett Leach, Regulatory Affairs Specialist