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Pepperdine University
Graduate School of Education and Psychology

EXAMINING TRAINEE THERAPISTS' USE OF RECOMMENDED COUNSELING
STRATEGIES FOR FACILITATING POSTTRAUMATIC GROWTH IN PSYCHOTHERAPY
WITH CLIENTS WHO HAVE EXPERIENCED TRAUMA: A QUALITITATIVE ANALYSIS

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Renée Marie Sloane Alas

February, 2017

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This clinical dissertation, written by

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DOCTOR OF PSYCHOLOGY

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DEDICATION

To Alex

To the Leukemia and Lymphoma Society

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ABSTRACT

Posttraumatic growth (PTG) describes the experience of positive changes following one's struggle with trauma. Calhoun and Tedeschi (1999) recommended counseling strategies for how therapists may facilitate the process of PTG within psychotherapy with clients. Because the efficacy of these strategies had not yet been assessed empirically, this study sought to qualitatively explore their use by trainee therapists, an unstudied population in the PTG literature. A total of 9 videotaped psychotherapy sessions conducted with 5 clients at 2 community counseling centers were selected for analysis. Directed content analysis using a coding system developed for this study was employed to analyze therapist responses to clients' discussions of trauma. Results indicated that the therapists in this study most commonly used responses consistent with Calhoun and Tedeschi's (1999) Recommendation #1 *Focus on Listening Without Trying to Solve*. Specifically, the most frequently used responses were *minimal encouraging* ($M = 86.9, SD = 69.7$), followed by *closed-ended questions about factual information* ($M = 20.8, SD = 16.1$) and *reflecting factual information* ($M = 20.6, SD = 15.7$) in both *early* and *later* sessions. Overall, therapists responded to *descriptions* of the clients' traumatic events and *evaluative* content such as thoughts, beliefs, and attitudes about the traumatic event, more so than *affective* content such as one's feelings and emotions. Across participants, Recommendations #2, #3 and #4 were rarely used to promote growthful experiences among individuals suffering from trauma and adversity, and missed opportunities for growth were also identified by the researcher. As a result, this study offers additional recommendations to include in Calhoun and Tedeschi's (1999) counseling strategies for facilitating PTG, and speaks to the need for graduate clinical psychology programs to train students in facilitating client strengths and PTG following trauma.

Chapter 1. Literature Review

The notion that suffering and distress can be possible sources of positive change has existed for thousands of years and has been expressed in philosophy, literature, spirituality, and religion. In the field of psychology, the positive psychology movement continues the work of humanistic, community, social and developmental psychology by positing that strengths, health, fulfillment, and wellbeing are integral components of the human experience and not mutually exclusive to illness, dysfunction, and distress (Seligman & Csikszentmihalyi, 2000). Linley and Joseph (2004) suggested that one direction of the positive psychology movement is to show how positive psychological approaches can be applied to both trauma and suffering.

More specifically, a focus on the possibility of growth from individuals' struggle with trauma has emerged as part of the positive psychology theoretical and research literature (Seligman & Csikszentmihalyi, 2000). For example, *posttraumatic growth* (PTG) describes the experience of positive changes following trauma and adversity in which an individual's development has surpassed his or her pre-trauma level of functioning (Tedeschi & Calhoun, 1996). Although evidence suggests that PTG impacts levels of distress, wellbeing, and other areas of mental health (Zoellner & Maercker, 2006), little is known about the processes and factors of this growth experience (Tedeschi & Calhoun, 2004). Calhoun and Tedeschi (1999) posited several counseling strategies for facilitating the PTG process in psychotherapy.

Research examining the utilization of Calhoun and Tedeschi's (1999) recommendations in psychotherapy, as well as this process with trainee therapists, is nonexistent. As such, this qualitative study explores the extent to which trainee therapists utilize a strength-based approach to facilitate PTG by following recommended counseling strategies that may be similar to those they have learned in their training. More specifically, it explores the extent to which trainee

therapists follow Calhoun and Tedeschi's (1999) recommendations for facilitating the PTG of clients who have previously experienced trauma. First, a review of the literature defines trauma, examines its potential consequences, and explores how trauma is discussed in the context of psychotherapy. Next, definitions and theories of growth following trauma as well as current ways to measure it are reviewed. Finally, this section focuses on current recommendations for and any relevant research on how therapists can help facilitate growth for clients who have experienced trauma. This section concludes with a description of the purpose of the study and its research questions.

Trauma

Often the term *trauma* is used to refer to (a) exposure to negative events that produce distress, as well as (b) psychological reactions to the traumatic event itself (Briere & Scott, 2006), such as individuals' reactions to an event or even the effects of an event such as symptoms and other mental disorders (Hall & Sales, 2008). An event is considered to be traumatic if it is extremely upsetting and at least temporarily overwhelms the individual's internal resources that usually give the person a sense of control, connection, and meaning (Herman, 1997). Traumatic stress, which can violate one's existing way of making sense of one's self and the world and has the potential to create intense fear and destabilization, has been differentiated from nontraumatic stress in that nontraumatic stress requires coping but not restructuring of one's ability to make meaning (McFarlane & Girolama, 1996). Hall and Sales (2008) noted that trauma may be conservatively equated with the symptomology or diagnosis of Posttraumatic Stress Disorder (PTSD), or types of events that may lead to traumatic stress disorders. Tedeschi and Calhoun (2004) broadly used the term *trauma* interchangeably with

crisis and *highly stressful events* to signify that these expressions represent significant challenges to one's ability to adapt and understand the world and one's place in it (Janoff-Bulman, 1992).

In contrast to the isolated incidents that tend to produce discrete conditioned behavioral and biological responses to reminders of the trauma such as those captured in the PTSD diagnosis, the traumatic stress field has more recently adopted the terms *complex trauma*, developmental trauma disorder (DTD; van der Kolk, 2005) to describe the experience of multiple, chronic, and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature (van der Kolk, 2005), and complex PTSD (CPTSD; Courtois, 2008).

Courtois and Ford (2009) noted,

Complex traumatic stress disorders therefore go well beyond what is defined as the classic clinically significant definitions (Criterion A) and beyond the triad of criteria (intrusive re-experiencing of traumatic memories, avoidance of reminders of traumatic memories and emotional numbing, and hyperarousal in Criteria B-D) that make up the diagnosis of posttraumatic stress disorder. (p. 2)

Complex psychological trauma is defined as resulting from exposure to severe stressors that (a) are repetitive and chronic, (b) involve harm or abandonment by caregivers or other responsible adults, and (c) occur at developmentally vulnerable times in the victim's/survivor's life, such as early childhood or adolescence when critical periods of brain development are rapidly occurring or being consolidated. Complex trauma often leaves the child unable to self-regulate (control feelings, cognitions, beliefs, actions), achieve a sense of self-integrity (belief that one is unique, whole, worthy), or experience relationships as nurturing, reliable and supportive resources (Ford & Courtois, 2009).

Similarly, a diagnosis of DTD requires the experience of threat to one's self-integrity posed by developmentally adverse interpersonal stressors, particularly when interwoven into a developing child's primary family/caregiver relationships, and induces both long-term biological

and psychosocial stress reactivity in the absence of life threat or violation of bodily integrity (Ford & Courtois, 2009). DTD includes two primary features, including (a) stressor-triggered dysregulation that occurs when trauma-related cues occur, and (b) beliefs that are altered by persistent experiences with abandonment, betrayal, and other forms of victimization that potentially influence the child's personality development.

The pervasive and varied symptoms associated with repeated trauma have also been characterized as *complex PTSD* (Herman, 1997), and *Disorders of Extreme Stress* (DESNOS; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). These constructs refer to a broad range of symptom clusters such as affect dysregulation, relational problems, cognitive distortions, dissociation, tension reduction behaviors, and somatization (Pelcovitz et al., 1997). Ford and Courtois (2009) also noted that complex trauma impacts one's personality development, attachment security, and self-regulation.

Treatment of complex posttraumatic self-regulation often begins with enhancing safety and stabilizing suicidality, impulsivity, and pathological dissociation (Ford, Courtois, Steele, Van der Hart, & Nijenhuis, 2005). Safety requires control of maladaptive behaviors such as self-harm, suicidality, unhealthy risk taking, substance abuse, eating disorders, and tolerating or inflicting relational aggression (Ford et al., 2005). Developing an empathic, consistent working alliance that supports and guides the client throughout therapy serves as a model for "containing" rather than avoiding or flooding intense emotions and impulses (Ford et al., 2005).

Other negative responses to traumatic events may include depression, complicated or traumatic grief, psychotic depression, anxiety, generalized anxiety, panic, phobic anxiety, PTSD, acute stress disorder, dissociation, drug and alcohol abuse, somatization disorder, and borderline personality disorder (Briere & Scott, 2006; Herman, 1997; van der Kolk, McFarlane, &

Weisaeth, 1996). Other responses to trauma including helplessness, shame, grief, loss of connection with one's spirituality, and disruption of one's ability to hope and trust (Briere & Scott, 2006; Hall & Sales, 2008).

A more broad definition of trauma includes threats to one's psychological integrity (Briere & Scott, 2006), as well as one's reactions and responses to the events themselves (Hall & Sales, 2008). Researchers seem to have difficulty agreeing upon what constitutes trauma, as definitions waver between objective and subjective components (Hall & Sales, 2008). Briere and Scott suggested that trauma applies to both threats to *psychological* integrity and threats to *physical* integrity, whereas definitions of trauma in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association [APA], 2000) only apply to threatened *physical* integrity to meet criteria for a traumatic stress diagnosis.

DSM criteria for PTSD have typically been used to guide the study and assessment of trauma, such as examining the estimated life prevalence of PTSD, types of trauma experienced, socio-demographic correlates, comorbidity of PTSD with other disorders, and duration of episodes. For example, using data obtained from the National Comorbidity Survey (NCS) that examined the general population epidemiology of PTSD, Kessler, Sonnega, Bromet, Hughes, and Nelson (1995) reported that 60% of men and 50% of women have experienced a traumatic event at some point in their lives, and that the majority of individuals who have experienced trauma reported two or more events. The NCS also revealed that men and women differ in the type of traumatic events they are likely to experience, in which men are more likely to witness or experience injury or death, life-threatening accidents, physical attack, combat, threat with a weapon, captivity, or kidnapping, whereas women are more likely to experience rape, sexual molestation, childhood parental neglect, and childhood physical abuse (Kessler et al., 1995).

General population estimates of lifetime PTSD in the NCS are 5% for men and 10% for women, with the lifetime prevalence of 8% in men and 20% in women (Kessler et al., 1995). The prevalence of trauma can be even higher in clinical populations, in which 80% or more of treatment-seeking individuals may have been traumatized (Kessler et al., 1995).

Because the NCS study used the DSM-III-R's definition of trauma to guide its research, traumas that may qualify as threats to psychological integrity as opposed to physical integrity may not have been accounted for in this study as well as in other studies that use DSM criteria to define trauma. Traumas that involve threats to psychological integrity may include extreme emotional abuse, major losses or separations, degradation or humiliation, coerced (but not physically threatened or forced) sexual experiences (Briere & Scott, 2006), and racism (Bryant-Davis & Ocampo, 2005). Because the DSM-IV-TR does not consider events to be traumatic if they are highly upsetting, but not life threatening, the DSM-IV-TR likely underestimates the extent to which trauma is reported in the general population (Briere & Scott, 2006).

Different cultures and subcultures may also experience trauma and express posttraumatic symptoms differently than how they are expressed in American society (Briere & Scott, 2006). PTSD is considered to be partially culture bound, since it best describes posttraumatic symptomology of those born and raised in Anglo/European countries (Briere & Scott, 2006). For example, the DSM-IV-TR acknowledges several culture-bound syndromes that appear to involve dissociation, somatization, and anxiety-related responses (i.e., *ataques de nervios*).

Racial/ethnic minorities and women are more frequently exposed to events that produce traumatic stress (Briere & Scott, 2006). In American society, non-Caucasian individuals and women frequently experience traumas that are related to racial and sexual inequalities (Briere, 2004). The traumas of racist incidents have been paralleled to the traumas of rape and domestic

violence. Like domestic violence, racism is not a single-event trauma and one must live with the threat of future violations; like rape, racist incidents are motivated by the drive for power wherein perpetrators maintain power and privilege by disseminating myths about those whom they victimize (Bryant-Davis & Ocampo, 2005). Victims of both rape and racist incidents may also have difficulty trusting and connecting with those who are similar to their perpetrators. In addition, racist incidents produce similar traumatic sequelae, particularly in clients of color. Briere and Scott also noted that in a Vietnam veterans study conducted by Kulka and colleagues (1988), Hispanic and African Americans were more likely to be exposed to high combat stress than Caucasians, and noted that they were likely victimized prior to joining the military (Briere & Scott, 2006).

Further, in Harrell's (2000) conceptualization of racism-related stress and its implications for the well-being of individuals of color, transgenerational transmission of trauma was described in one of the six proposed modes of racism-related stress. Harrell (2000) cited Root's conceptualization of the transgenerational transmission of trauma, including group traumas such as the slavery of African people, the interment of Japanese Americans during World War II, the removal of American Indians from their tribal lands, and refugee experiences to help describe how trauma-related behavior and beliefs about the world can relay the effects of historical traumas across generations. Racial/ethnic groups may also experience the trauma of racism in several general contexts, including at the interpersonal level, collective context such as the status and functioning of large groups of people, cultural-symbolic context such as in news, entertainment media, art, research inquiry, and in sociopolitical contexts (Harrell, 2000).

Although research on trauma within the field of psychology has generally focused on maladaptive behaviors and symptoms that result from traumatic events (Calhoun & Tedeschi,

2006), a positive psychological view focuses both on individuals' strengths and potential for psychological health following trauma and stressful life events, rather than solely on the maladaptive symptoms and behaviors. As such, this view is described in more detail next.

Trauma and positive psychology. Positive psychology attempts to redress what is perceived as an imbalance in the focus of research attention and practice objectives in psychology (Linley, Joseph, Harrington, & Wood, 2006). Specifically, one of its goals is to “synthesize the positive and the negative” (Linley et al., 2006, p. 11) in different areas of psychology, including applying psychological approaches to trauma and suffering (Joseph & Linley, 2005). Using the positive psychological approach of addressing positive functioning in addition to maladaptive functioning is of interest to researchers and clinicians because traumatic events do not always result in negative outcomes. More specifically, only a minority of the survivors will go on to develop PTSD, and with the passage of time, the symptoms will resolve in approximately two-thirds of these individuals (McFarlane & Yehuda, 1996; Tedeschi & Calhoun, 1999).

Research in positive psychology includes multiple theoretical and research areas that share a common focus on positive human functioning, psychological health, and adaptation to illness and other forms of adversity (Seligman & Csikszentmihalyi, 2000; Sheldon & King, 2001). To illustrate, while survivors of trauma often experience distressing emotions in response to a traumatic event, some may simultaneously experience PTG (Calhoun & Tedeschi, 2006). Further, research in the area of PTG shows that some individuals who have experienced trauma also experience positive changes in their perception of themselves, experiences of relationships with others, and philosophy of life (Calhoun & Tedeschi, 2006).

Specifically, scientific interest in positive psychology includes topics such as positive affect, meaning, mastery, personal growth, forgiveness, gratitude, hope, optimism, spirituality, and their relation to mental and physical health, and their potential for applications to promote well-being and health (Aspinwall & Tedeschi, 2010). For example, as it relates to well-being, psychological support by family members, friends, and others is known to reduce the intensity of posttraumatic stress (Aspinwall & Tedeschi, 2010).

Also, disclosure following traumas has also been associated with a lower level of distress (Bolton, Glenn, Orsillo, Roemer, & Litz, 2003), better physical functioning in daily activities (Kelley, Lumley, & Leisen, 1997), and a more resilient self-concept (Hemenover, 2003). As such, expressing one's thoughts or emotions following exposure to a highly stressful event may have positive consequences, while avoiding disclosure generally has negative effects (Taku, Tedeschi, Cann, & Calhoun, 2009). Because these results suggest that something inherent in the disclosure process following trauma may promote well-being, it will be described further.

Discussion of trauma. At its most basic level, self-disclosure is defined as personal information verbally communicated to another person (Chelune, 1979; Cozby, 1973). This personal information may include descriptive content in which one discloses facts about him or herself, evaluative information in which one expresses beliefs, opinions and attitudes, and affective disclosures which includes information about one's moods and emotions (Omarzu, 2000). Similarly, Pennebaker, Zech, and Rimé (2001) consider disclosure as verbalizations of emotional experiences and events. Further, Jourard (1971) defined disclosure as the sharing of deeply held thoughts and beliefs with others.

Within the child sexual abuse (CSA) literature, disclosure is defined as the accidental, purposeful, or prompted/elicited telling or reporting of abuse (Alaggia, 2004). The word

disclosure is more commonly used when referring to a child's reporting of abuse, while *telling* more often describes adults sharing their abuse experiences (Alaggia, 2004). For example, Brison (1999) suggests that by constructing and discussing/telling a narrative of the trauma endured, the survivor can begin to integrate the traumatic episode into his or her life with a "before and after" with the help of understanding listeners. The individual can also gain control over the occurrence of intrusive memories (Brison, 1999). Using the term disclosure has been problematic in the literature because it often connotes a static event, rather than a fluid process experienced by the individual (Alaggia, 2004). Disclosure also refers to "telling the secret" to family members or significant others for the first time (Roesler & Wind, 1994). Alaggia (2004) recommended that the conceptualization of disclosure be expanded to include behavioral and indirect verbal attempts, disclosures intentionally withheld, and disclosures that were triggered by recovered memories. As such, use of the term "discussion" may better describe these various aspects of the disclosure process as opposed to only referring to a first time telling of the event.

According to Pennebaker (1995), there are a number of ways in which disclosure or discussion of trauma is believed to facilitate the healing process. Disclosure can (a) facilitate learning more about the actual event and about one's reactions to the event, (b) change the way in which the event is mentally represented and remembered, and (c) facilitate habituation to the event. Further, McAdams (1996) and Janoff-Bulman (1992) suggested that individuals create self-narratives to help them make sense of who they are in the world as they change over time. Disclosure also potentially allows individuals to explain and organize distressing life events (Pennebaker & Keough, 1999). Further, it may lead to repairs in a damaged sense of self and lead to a more resilient self-concept (Pennebaker & Keough, 1999; Pennebaker, Mayne, & Francis, 1997). In addition, Pennebaker and Beall (1986) observed that writing about factual

aspects of an emotional episode did not affect health variables in a sample of male and female undergraduate psychology students (race/ethnicity was not specified), while writing about the emotional aspects did. Writing about a traumatic event also reduced distress in a sample of college students (Pennebaker, 1997).

In a recent study of a sample of Japanese university students, positive psychological changes experienced as a result of struggling with crises and trauma, or PTG, was higher in those who disclosed a traumatic event, and who perceived their recipients' reactions as supportive through mutual disclosure (working through together), listening, encouraging, and sympathizing, as opposed to recipients' reactions perceived as unsupportive, such as being confused or showing high distress (Taku et al., 2009). This suggests that sharing one's thoughts and feelings about distress and one's experience of trauma as well as the response of those individuals to whom the telling is made, may help facilitate positive changes or growth in individuals who have experienced suffering and are able to share it with a supportive other. As such, additional research is recommended to identify fundamental aspects of self-disclosing in individuals and recipients that may impede or foster this growth process (Taku et al., 2009).

Knowledge of this self-disclosure process, including how one's culture may influence one's experience of PTG, would also be valuable in psychotherapy, as therapists may be able to help their clients to facilitate growth following trauma or highly stressful events (Calhoun & Tedeschi, 1999). Because this process in psychotherapy is of particular interest to this dissertation, growth is described next.

Growth

Defining growth. Growth can be broadly described as the act or process of development from a lower or simpler to a higher or more complex form, an increase as in size, number, value,

or strength, and as an extension or expansion (“Growth,” n.d.). In *Becoming a Person*, Carl Rogers (1961) refers to growth as an individual’s tendency to reorganize his or her personality and relationship to life in ways that are regarded as more mature. According to Rogers, this drive toward self-actualization is a forward-moving directional tendency; the urge evident in all organic and human life to expand, extend, become autonomous, develop, mature, express and activate all the capacities to the extent that such activation enhances the organism or the self. This actualizing tendency allows the individual to continually aim to fulfill his or her potential as a fully functioning person (Rogers, 1961). Rogers’ research emphasizes how psychotherapy can serve as a suitable psychological climate to release this growth tendency.

In more recent literature pertaining to goal attainment and psychological growth, Sheldon, Kasser, Smith, and Share (2002) describe two models in which personal growth occurs. In models of personality development, growth typically involves increasing self-awareness, self-acceptance, and social integration (Hy & Loevinger, 1996) and occurs when an individual succeeds through normative or age-graded role transitions or stages. As such, growth occurs at particular times in life or shifts in life-tasks or social roles (Snyder & Cantor, 1998). Also in the developmental psychology literature, rather than viewing growth solely in terms of stages or maturational development, Baltes, Staudinger, and Lindenberger (1999) view lifespan development in terms of the structure, sequence, and dynamics of the entire life course in the context of a changing society. In their theory, age-related dynamics between biology and culture impact three goals of ontogenetic development: growth, maintenance (including resilience), and the regulation of loss. Baltes and colleagues define growth as behaviors aimed at reaching higher levels of functioning or adaptive capacity.

The second type of personal growth develops in “catastrophe” models, which emphasize that personal growth occurs in response to emotional or psychic traumas (Tedeschi & Calhoun, 1995) or as a result of dramatic changes in life circumstances (Showers & Ryff, 1996). Such challenges may promote significant new organization within individuals’ personality systems (Ryan, 1995), and may help them gain new insight or rediscover important values (Tedeschi, Parks, & Calhoun, 1998). More specifically, the growth described in these “catastrophe” models has been termed posttraumatic growth (PTG), and refers to positive psychological change that occurs through the experience of struggling with trauma, crisis, or adversity (Tedeschi & Calhoun, 2004). Theories and examples of PTG are discussed next.

Growth following trauma. Growth following trauma or PTG is reported by individuals who have experienced a variety of events perceived, described, or experienced as difficult, tragic, catastrophic, and horrible (Tedeschi & Calhoun, 1999). PTG has been measured and found to exist in studies of individuals who have experienced traumas including rape, sexual abuse, combat, bereavement, refugee experiences, coping with medical problems in children, suffering severe injury, breast cancer, bone marrow transplantation, military combat and captivity, HIV/AIDS, rheumatoid arthritis, accidents, natural disasters, being taken hostage (for reviews of these studies, see Affleck & Tennen, 1996; Helgeson, Reynolds, & Tomich, 2006; Joseph & Linley, 2006; Sheikh, 2006; Tedeschi & Calhoun, 2006), and acculturation and immigration trauma (Foster, 2001; Weiss & Berger, 2010). Many individuals who have experienced traumatic events report being changed in positive ways by their struggle with trauma (Tedeschi & Calhoun, 1995; Park, 1998), as PTG is common but not universal (Tedeschi & Calhoun, 1999). Data suggests that 30% to 90% of persons facing serious life crises experienced

at least some positive change (Tedeschi & Calhoun, 1995). Growth following trauma is associated with less depression and more positive well being (Helgeson et al., 2006).

Growth following experiences of crises and trauma has been noted in both males and females across the lifespan, and across cultures. Sex differences have been reported, with women indicating more growth than men (Lehman et al., 1993; Park, Cohen, & Murch, 1996; Tedeschi & Calhoun, 1996). Recent studies suggest that this growth process may also occur among children and adolescents, an understudied population (Cryder, Kilmer, Tedeschi, & Calhoun, 2006; Milam, Ritt-Olson, & Unger, 2004). PTG has also been reported across cultures including among Bosnian, Latina, Israeli, Japanese, Chinese, Turkish, German, American, and British populations.

Studying positive changes following adversity or trauma across different populations is complex because research has examined growth in people experiencing very different kinds of stressful events, ranging from divorce and bereavement to environmental disasters and war to cancer (Park & Lechner, 2006). Some of these stressors are acute while others are more chronic (Park & Lechner, 2006). However, various models of growth following adversity and trauma attempt to transcend variables such as age and type of trauma by explaining and describing possible underlying processes of growth. Culture is also taken into consideration in some of these models. Many studies of growth may reflect the importance of religion and personal spirituality as a positive outcome of stressful or traumatic experiences because of the spiritual emphasis in American life rather than due to being a universal experience (Pals & McAdams, 2004). Individuals in the United States may say they have experienced growth following a stressor because their culture emphasizes that they are supposed to grow from stress (Linley &

Joseph, 2004), and social network members might react negatively to reports of distress (Wortman, 2004).

Although these theories have their limitations, the relatively new study of PTG invites others to explore these issues and how they impact mental health. As such, various terms have been used interchangeably in the literature to study and describe positive changes or growth following trauma or highly stressful events. After describing these terms and related concepts, early foundational models as well as the most current models of growth following adversity are discussed.

Terminology used to define growth following trauma. Various constructs have been used in the literature to examine and describe growth in individuals following trauma and adversity. Growth has been studied theoretically in the literature, and more recently in empirical research including *adversarial growth* (Linley & Joseph, 2004), *perceived benefits* (McMillen & Fisher, 1998), *stress-related growth* (Park, Cohen, & Murch, 1996), *thriving* (O’Leary & Ickovics, 1995; Abraido-Lanza, Guier, & Colon, 1998), *benefit-finding* (Affleck & Tennen, 1996), *heightened existential awareness* (Yalom & Lieberman, 1991), *positive by-products* (McMillen & Cook, 2003), *positive illusions* (Taylor & Brown, 1988), *posttraumatic success* (O’Hanlon, 1999), and *posttraumatic growth* (PTG; Tedeschi & Calhoun, 1996). This subsection reviews these terms as well as the related concepts of *resilience*, *hardiness*, *optimism*, and *positive emotions*.

Adversarial growth. In Joseph and Linley’s (2006) review of theoretical perspectives of growth and their implications for clinical practice, they collectively referred to the positive changes resulting from the struggle with adversity as *adversarial growth*. Fortune, Richards, Griffiths, and Main (2005) used Joseph and Linley’s term in their study in which they identified

predictors of adversarial growth in patients undergoing treatment for psoriasis, including younger age at onset, stronger beliefs that psoriasis would be recurrent or chronic, and lower scores on alexithymia.

Perceived benefits. McMillen, Smith, and Fisher (1997) referred to the *perceived benefit phenomenon* as the process by which those who have experienced traumatic events report benefit and growth as a result of their experiences. McMillen and Fisher (1998) stated that individuals commonly report that they have benefited from the negative events they have experienced. McMillen et al. examined perceived benefits and mental health adjustment after three different types of disaster including a tornado, mass killing, and a plane crash, in which participants reported some positive life changes even though they clearly suffered from the events they experienced and continued to experience the negative effects of these stressors. Perceived benefits were also studied by Polatinsky and Esprey (2000), who found that bereaved parents perceived benefits from their experiences of coping with the loss of a child.

Stress-related growth. Park, Cohen, and Murch (1996) conceptualized stress-related growth as positive changes in the aftermath of stressful life experiences. Stress-related growth is influenced by the conceptual model of Schaefer and Moos (1992), which proposed that personal and environmental factors shape the cognitive appraisal and coping responses used by the person following a life crisis. The subsequent effective use of these appraisal coping responses would determine the positive resolution of the crisis. Casterta, Lund, Utz, and de Vries (2009) found that bereaved spouses were more likely to experience stress-related growth if they anticipated their partner's death and used their religious beliefs to find meaning and make sense of what happened.

Thriving. O'Leary and Ickovics (1995) described three possible outcomes following challenge: survival, recovery, or thriving. Unlike survival and recovery, thriving refers to the ability to go beyond the original level of psychosocial functioning, and to grow or flourish as a result of confronting adversity (O'Leary & Ickovics, 1995). According to O'Leary and Ickovics, the availability of individual and social resources enhances one's ability to thrive.

Abraido-Lanza, Guier, and Colon (1998) applied O'Leary and Ickovics' (1995) thriving paradigm. They conceptualized thriving in terms of a "value-added model," as it implies one has experienced growth by finding strength, new insight, or meaning in life as the result of chronic illness (Abraido-Lanza et al., 1998). Abraido-Lanza and colleagues studied a population of chronically ill Latina women of low socioeconomic status and found greater self-esteem, self-efficacy, and well-being to be related to thriving.

Benefit-finding. Affleck and Tennen (1996) used this term to describe when individuals facing their own or loved ones' severe medical problems cite benefits, gains, or advantages from their adversity. Write, Crawford, and Sebastian's (2007) study of benefit-finding in women with histories of childhood sexual abuse identified benefits such as improved relationships with others, religious or spiritual growth, and improved parenting skills.

Heightened existential awareness. Yalom (1980) stated that in his work with terminally ill cancer patients, he observed that many use their crisis as an opportunity for change. He described how they reported personal growth in the following ways: (a) rearrangement of life's priorities, (b) life lived more in the present moment as opposed to postponing experiences for the future, (c) deeper communication with family and close friends, (d) fewer fears, less concern about rejection, and greater willingness to take risks, and (e) a greater appreciation for elemental facts of life. Yalom and Lieberman (1991) referred to this personal growth following crisis as

heightened existential awareness, and studied it in the context of a group therapy format for a nonclinical sample of bereaved spouses.

Positive by-products. McMillen and Cook (2003) referred to positive by-products as unexpected positive outcomes that accrue from the struggle with traumatic events in their study of individuals with traumatic spinal cord injury. They found that increased compassion and family closeness and decreased alcohol consumption were commonly reported positive by-products following injury. In a study of individuals struggling with chemical dependency participants experienced positive by-products from their struggle with addiction such as feeling closer to family and non-family members, increased self-efficacy, compassion and spirituality, decreased naiveté, and knowledge that they could impart to their children with substance and alcohol issues (McMillen, Howard, Nower, & Chung, 2001).

Positive illusions. Taylor (1983) argued that when individuals experience a trauma or setback, they respond with cognitively adaptive efforts that may enable them to return to or exceed their previous form of self-perception and world knowledge. Taylor and colleagues (Taylor, 1983; Taylor & Armor, 1996; Taylor, Kemeny, Reed, Bower, & Gruenewald, 2000) asserted that the following positive illusions typically characterize people's beliefs after experiencing threatening events or information: (a) mildly distorted positive perceptions of themselves (self-aggrandizement), (b) an exaggerated sense of personal control, and (c) unrealistic optimism. Through their research initially derived from work with cancer patients, Taylor and Brown (1988) suggested that positive illusions promote psychological well-being and may promote other aspects of mental health including the ability to engage in productive or creative work, the capacity to care about others, and the ability to be happy or content. Without

this form of coping, individuals using cognitive-processing may distort incoming information as threatening.

Some suggested that positive illusions might seem to be analogous to denial, avoidance, wishful thinking, or distortion of meaning (Maercker & Zoellner, 2004). However, Taylor and Armor (1996) countered that positive illusions represent individual's beliefs about their own personal qualities and their degree of personal control, whereas wish fulfillment and denial are more focused on how one wants external circumstances to be when they are not.

Posttraumatic success. O'Hanlon (1999), a solution-focused psychotherapist, proposed a way to resolve trauma by working with clients in the present toward the future, including helping the client (a) acknowledge facts as well as the present and former inner experience of trauma; (b) value, own, and associate with dissociated aspects of one's self; and (c) develop a clear sense of a future with possibilities. He provided several guidelines for promoting posttraumatic success in psychotherapy in working with trauma survivors, which is discussed in more detail later. Using O'Hanlon's model, Bannink (2008) suggested that the focus in psychotherapy should shift from impossibilities to possibilities and from posttraumatic stress to posttraumatic success.

O'Hanlon also describes *the three C's of spirituality* as sources of resilience: (a) connection with something bigger, within, or outside oneself, (b) compassion regarding one's attitude toward the self, and (c) contribution of service to others. These different aspects of spirituality may also be valuable in the study of how individuals of different cultures and subcultures may experience growth following trauma.

Posttraumatic growth. The term posttraumatic growth (PTG) was coined by Tedeschi and Calhoun (1996), and refers to positive psychological change experienced as a result of the

struggle with highly challenging life circumstances. It describes a qualitative change in functioning indicative of individual development that has surpassed one's pre-trauma level of functioning, as opposed to a return to a baseline functioning (Tedeschi & Calhoun, 2004). PTG connotes (a) conditions of major crises rather than lower levels of stress, (b) genuine transformative life changes that go beyond illusion, (c) an ongoing process or outcome, rather than a coping mechanism, (d) significant threat or the shattering of fundamental schemas, and (e) may co-exist with significant psychological distress (Tedeschi & Calhoun, 2004). In their definition, Tedeschi and Calhoun broadly used the term *trauma* interchangeably with *crisis* and *highly stressful events* to signify that these expressions represent significant challenges to one's ability to adapt and understand the world and one's place in it (Janoff-Bulman, 1992).

Accordingly, Tedeschi and Calhoun (2004) noted that their definition of trauma is less exclusive than its usage in the DSM-IV-TR which restricts the definition of trauma to exposure to actual or threatened death, physical integrity, or serious injury to oneself or loved ones. For example, Cordova, Cunningham, Carlson, and Andrykowski (2001) found that breast cancer survivors reported PTG, especially in relating to others, appreciation of life, and spiritual change. In a study by Milam (2004), the process of experiencing PTG in HIV/AIDS patients was associated with lower levels of depression.

Cross-cultural differences in the experience and expression of growth following adversity and trauma should also be considered when trying to understand PTG. Authors have argued that one's culture largely determines the types of growth that are likely to occur (Park & Lechner, 2006). Changing one's priorities and finding new paths in life may imply a level of flexibility and independence characteristic of Western cultures that emphasize individuality over collectivism (Ho, Chan, & Ho, 2004). However, Ho, Chan, and Ho suggested that there are

some universal dimensions of PTG that are less affected by culture, characteristics of the population, and nature of the crisis, given results of their study in which ratings of the self, interpersonal, and spiritual domains of the Posttraumatic Growth Inventory (PTGI) in a sample of Chinese cancer survivors were similar to findings in Western studies.

Closely associated constructs. The following terms are closely associated with constructs in the literature that describe growth following trauma. The following constructs of resilience, hardiness, optimism, and positive emotions are reviewed.

Resilience. The concept of psychological resilience was originally developed in the field of child and adolescent developmental psychopathology (Cicchetti, 1987; Garmenzy, 1991; Rutter, 1987). The term was used to describe children who do not experience dysfunction socially despite growing up in dire socioeconomic conditions. Garmenzy (1991) defined resilience more generally as the capacity for recovery and maintained adaptive behavior following a stressful event, and Rutter (1987) described it as individuals' positive responses to stress and adversity. These definitions imply that the concept of psychological resilience explains two types of phenomena: (a) the maintenance of normal development despite risks and impairments, and (b) the recovery of normal functioning after a traumatic experience (Staudinger, Freund, Linden, & Maas, 1999). Thus, in the literature, resilience describes both the process of confronting risks and their outcomes (Rutter, 1987).

As it relates to grief and loss literature, Bonanno (2005) described resilience as characterized by a relatively mild and short-lived disruption in normal functioning and a stable trajectory of healthy functioning across time. In contrast, *recovery* can take months to achieve, as returning to pre-trauma levels of functioning is hampered by moderate to severe initial elevations in psychological symptoms that significantly disrupt functioning. Though they may

struggle for a short period of time with symptoms of distress following a trauma, resilient individuals continue functioning effectively at or near their normal level of functioning (Bonanno, Moskowitz, Papa, & Folkman, 2005). Resilience has been linked to continued fulfillment of personal and social responsibilities and the capacity for engaging in new creative activities and relationships both immediately and in months following exposure to a potentially traumatic event (Fredrickson, Tugade, Waugh, & Larkin, 2003).

Hardiness. Integrating existential theory of personality with various social, developmental, and personality research, Kobasa (1979) originally proposed hardiness as a personality style that is a source of positive resistance to the debilitating effects of stressful life events on health. Hardiness is said to not only facilitate survival in the face of stress but also promote enrichment in life (Kobasa, 1979). Hardiness theory posits that hardy individuals possess three crucial personality characteristics, or interrelated attitudes, known as the “3Cs”: *commitment, control, and challenge* (Kobasa, 1979; Maddi & Kobasa, 1984). Individuals strong in commitment turn their experiences into something that seems interesting and important to them, and may have a tendency to get involved rather than feel alienated. Individuals strong in control believe that through effort they can often influence the course of events in their lives, as opposed to passively seeing themselves as victims of circumstance. Individuals strong in challenge find fulfillment in continual growth in wisdom through learning from life experiences, rather than through comfort, security, and routine (Maddi et al., 1998). The most current hardiness measure (PVS-III-R) consists of items written specifically relevant to hardiness appraisals of commitment, control, and challenge. Sinclair and Tetrick (2000) confirmed through factor analysis and other multivariate analyses that commitment, control, and challenge are best regarded as related subcomponents of a higher-order hardiness factor and that this factor is

empirically distinct from negative affectivity or neuroticism in a sample of culturally diverse undergraduate psychology students (50% Caucasian, 35% African American, 15% other ethnicities).

Hardiness was first studied as a basis for resilience in a 12-year study conducted from 1975 through 1987 that followed a sample of predominantly married Protestant Caucasian men employed as middle- and upper-level managers with the Illinois Bell Telephone (IBT) company. The purpose of the study was to determine whether there were individual differences in the workers' reactions to experiences of major stressors that could be understood by hardiness theory. The IBT study showed that employees scoring high in hardy attitudes showed the action pattern of coping with stressful circumstances by facing them rather than being in denial, and struggling to turn them from potential disasters into opportunities for themselves and the company, rather than avoiding them or blaming others. Participants also exhibited supportive social interactions and facilitative self-care under stresses (Maddi & Kobasa, 1984). Kobasa, Maddi, and Puccetti (1982) suggested from their results using this same sample in an earlier study, that individuals who display hardiness make optimistic cognitive appraisals about change, such that it is natural, meaningful, and interesting, despite the stress that may be involved with change. Thus, they posit that these beliefs and tendencies may be useful in coping with stressful events.

More recently, the relationship of hardiness to performance, conduct, and health has been examined in samples of people in diverse occupations (e.g., bus drivers, lawyers, nurses, firefighters; for a review, see Maddi, 2006). Additionally, Bartone (1999) demonstrated in his work studying military personnel in combat and peace keeping missions that the higher hardiness attitudes were prior to leaving on missions, the less likely life-threatening experiences abroad led

to posttraumatic stress or depressive disorders. Evaluation studies of Khoshaba and Maddi's (1999) hardiness-training program showed that hardiness training not only increases hardy attitudes and actions, but also improves performance and health in working adults and college students (Maddi, Kahn, & Maddi, 1998; Maddi, Khoshaba, Jensen, Carter, Lu, & Harvey, 2002).

Additionally, in a hardiness construct validation study comparing the PVS-III-R with other measures of emotions, attitudes, and beliefs concerning oneself and one's interactions with the environment using 11 samples (2,752 participants combined) of racially/ethnically diverse Southern California undergraduate students (Caucasian, Asian, Hispanic, African American, and Middle Eastern individuals), hardiness was found to be negatively related to depression, anxiety, and hostility, as well as negatively related to avoidance of intrusive stressful thoughts (Maddi, Harvey, Khoshaba, Fazel, & Resurreccion, 2009). Hardiness was also associated with positive attitudes toward school, instructors, and one's own capabilities and standards as well as expressed satisfaction with life (Maddi, Harvey, Khoshaba, Fazel, & Resurreccion, 2009).

Optimism. Optimism is defined as an individual difference variable that reflects the extent to which people hold generalized favorable expectancies for their future (Carver, Scheier, & Segerstrom, 2010). In their review of the optimism literature, Taylor and Armor (1996) made the distinction between *naïve optimism* and *active optimism*. They suggested that naïve optimism is the belief that things will turn out okay, and active optimism is the belief that things will turn out okay due to one's own resources and efforts to ensure that they become or stay that way (Taylor & Armor, 1996).

Optimism and pessimism can be thought of as the confidence or doubt in which individuals generally approach life, as opposed to how they solely approach particular contexts (Scheier & Carver, 1992). As such, optimism is a trait with relatively high test-retest

correlations over few weeks to 3 years, and longer (Atienza, Stephens, & Townsend, 2004), and has a heritability estimate of approximately 25% (Plomin, Scheier, Burgeman, Pederson, Nesselrode, & McClearn, 1992).

Unlike individuals who demonstrate pessimism such as in the form of doubt and hesitancy, those who demonstrate optimism tend to be confident and persistent in the face of diverse life challenges (Carver et al., 2010). Similarly, optimism by definition is inversely related to hopelessness, a risk factor for depressive disorders (Alloy et al., 2006). These differences in how individuals confront adversity have implications for success in completing goal-directed behavior as well as how they cope with stress (Carver et al., 2010). Higher levels of optimism have been related to better subjective well being in times of adversity or difficulty, as well as better physical health (Carver et al., 2010).

In a study using a sample of male and female undergraduate students (race/ethnicity was not specified), active optimism, which is more constructive, was associated with better psychological adjustment whereas naïve optimism was not (Epstein & Meier, 1989). Additionally, in Tedeschi and Calhoun's (1996) development of the Posttraumatic Growth Inventory (PTGI), which also used a university sample, perceiving benefits following experiences of trauma and adversity was most consistently associated with personality traits of extraversion, openness to internal experience, and optimism. This finding suggests that personality traits such as optimism might enhance the likelihood that individuals may experience PTG (Tedeschi & Calhoun, 1996). In their review of the optimism literature, Carver and colleagues (2010) noted that many of the studies examining optimism used samples consisting of North Americans of mostly European descent, and that studies have been mixed as far as

generalizing optimism findings to other ethnic groups (see Chang, 2002; Chang, Sanna, & Yang, 2003).

Positive emotions. Fredrickson and Joiner (2002) proposed that positive emotions not only feel good in the present, but also trigger upward spirals toward enhanced emotional well-being. Fredrickson's (1998, 2001) *broaden and build theory* posits that unlike negative emotions which narrow one's thought-action repertoires, positive emotions broaden these repertoires encouraging one to explore and discover new lines of thought or action. Fredrickson suggests that an outcome to this broadening of thought-action repertoires is an increase in personal resources. As individuals discover new ideas and actions, they build their psychological, social, intellectual, and physical resources (Fredrickson, 1998, 2001). For example, joy promotes play, which builds socioemotional skills and fuels brain development, and interest promotes exploration, which in turn increases knowledge and psychological flexibility (Fredrickson & Joiner, 2002).

Positive emotions have been found to produce wider visual search patterns, novel and creative thoughts and actions, more inclusive social groups, and more flexible goals and mindsets in male and female (race/ethnicity was not specified) undergraduate students (Ashby, Isen, & Turken, 1999; Fredrickson & Cohn, 2008). Additionally, a randomized controlled trial of loving-kindness meditation showed that individuals in a population of female and male employees (Caucasian, 73%; African American, 9%; South Asian, 6%) working for a large business software and information technology services company who learned to self-generate feelings of compassion and love also built resources (Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008).

Models of growth. To gain a better understanding of growth following trauma and adversity, O’Leary, Alday, and Ickovics (1998) identified eight foundational theoretical models of growth in the literature, including three models of intentional change and five models of unintentional change. Models of intentional change include Nerken’s (1993) model of growth following loss, Mahoney’s (1982) model of human change processes, and Hager’s (1992) model of chaos and growth. These models describe a slow, incremental, constant process that may include periods of inaction or “backsliding,” such as during the course of psychotherapy in the treatment of depression or substance use (O’Leary, Alday, & Ickovics, 1998). According to Joseph and Linley (2006), the three models of intentional growth emphasize that growth arises through the reorganization and redevelopment of cognitive structures, and that the breakdown of existing views of the world activates the rebuilding of the more effective worldviews.

Models of unintentional change include those by Schaefer and Moos (1992), Miller and C’deBaca (1994), O’Leary and Ickovics (1995), Tedeschi and Calhoun (1998), and Aldwin (1994). These models describe a process of transformation in which an individual experiences growth resulting from an unexpected tragedy or crisis (Joseph & Linley, 2006). The five models of transformative unintentional change emphasize the interaction between personality, cognitive appraisal, and coping activity (Armeli, Gunthert, & Cohen, 2001; Linley & Joseph, 2004; O’Leary & Ickovics, 1995; Park, 1998; Schaefer & Moos, 1992; Tedeschi & Calhoun, 1995).

Joseph and Linley (2006) noted that modern adversarial growth theories have drawn on these foundational models developed by psychosocial theorists, and utilize many of the constructs used to understand posttraumatic stress and growth. Three current theoretical models are discussed in detail next.

Joseph and Linley's organismic valuing theory of growth through adversity.

According to Joseph and Linley (2005), organismic valuing theory of growth through adversity states that individuals are intrinsically motivated toward rebuilding their assumptive worlds following a trauma in a direction consistent with their inherent tendencies toward growth and actualization. Joseph and Linley synthesized several theoretical principles to support their theory of growth through adversity. The organismic valuing process (OVP), one of the most prominent concepts within humanistic psychology, was originally discussed by Carl Rogers in 1951 (Sheldon, Arndt, & Houser-Marko, 2003). It refers to one's innate tendency to know and choose his or her best pathway toward wellbeing and fulfillment in life; to self-actualize one's potentialities. Joseph and Linley posited that the OVP is more likely to occur when conditions within the individual's environment are supportive. When the social environment meets the individual's psychological needs for *autonomy*, *competence*, and *relatedness*, this theory posits that individuals will grow by following human nature to modify their existing views of the world to positively accommodate new trauma-related information.

Joseph and Linley (2005) synthesized several other theoretical principles to support their theory of growth through adversity. An underlying completion tendency (Horowitz, 1986) exists that drives cognitive-emotional processing of posttraumatic stress reactions and integration of new trauma-related information. To make explicit in what way the completion tendency serves to integrate the new trauma-related information, Joseph and Linley use the principle that trauma-related information is processed in one of two ways (Hollon & Garber, 1988). It can be *assimilated* within existing models of the world, or existing models of the world must *accommodate* the new information (Hollon & Garber, 1988). Assimilation is an individual's

attempt to incorporate information to fit his or her existing models of the world as just and fair, whereas accommodation requires individuals to change their worldview (Janoff-Bulman, 1992).

Joseph and Linley (2005) integrated the role of meaning making (Janoff-Bulman & Frantz, 1997) in their theory using these models of assimilation and accommodation.

More specifically survivors may initially be concerned with questions of comprehension such as understanding the event and “why” it happened in which there are no satisfactory answers or resolution (i.e., *meaning as comprehensibility*), but over time they tend to ask questions of significance such as philosophical or spiritual implications (i.e., *meaning as significance*) (Janoff-Bulman & Frantz, 1997). Both forms of meaning are involved in understanding growth through adversity, but meaning as significance is necessary for growth (Joseph & Linley, 2005).

According to Joseph and Linley’s (2005) theory, individuals may not always positively accommodate trauma information and experience growth. Growth is not experienced when an individual’s trauma experience becomes *assimilated* into his current worldview (Joseph & Linley, 2005). This vulnerability can occur because one may utilize self-blame, as a means to keep the trauma experience consistent with his or her existing schema that the world is a safe place. As such, the individual returns to the pre-trauma baseline of functioning, but may be vulnerable to future retraumatization.

In addition, growth is not experienced when the individual *negatively accommodates* the trauma-related information (Joseph & Linley, 2005). Joseph and Linley’s model posited that if an individual’s needs have not been met in the past, and therefore the OVP had not been facilitated, one is more vulnerable to attributing self-blame as the reason for the occurrence of the trauma in an attempt to retain the pre-trauma schema. This negative accommodation of the

trauma-related information may manifest as psychopathology and distress, such as helplessness or hopelessness (Joseph & Linley, 2005).

Lastly, Joseph and Linley (2005) utilized theories of wellbeing (Keyes et al., 2002; Ryan & Deci, 2001) to posit that the aim of therapy should be for clinicians to foster growth by increasing wellbeing related to strengths, meaning, and purpose in life. Fostering of growth in therapy indirectly promotes well-being related to affective states such as reducing distress because, as it relates to trauma, the experience of growth is associated over time with subsequent decreases in symptoms (Joseph & Linley, 2005). In contrast, decreases in symptoms do not necessarily lead to growth (Joseph & Linley, 2005). Joseph and Linley used the work of Calhoun and Tedeschi (1999; Tedeschi & Calhoun, 2004) to conclude that a therapist can help facilitate the client's positive accommodation of new trauma-related information and wellbeing by listening attentively and actively to the client as well as help the client to more clearly articulate the client's own new meanings as they begin to emerge.

Christopher's biopsychosocial-evolutionary view of traumatic stress and growth.

Michael Christopher (2004) provided a biopsychosocial evolutionary approach to understanding the traumatic stress response and its role in adaptation, maladaptation, pathology, and growth. Joseph and Linley (2006) deemed Christopher's model as the most comprehensive and holistic account of growth to date. Fortune, Richards, Griffiths, and Main (2005) used Christopher's model in their discussion of assisting patients to develop the reconfiguration of meaning needed to turn recurrent stress into growth following adversity, while deemphasizing exclusive focus on symptom removal.

Christopher's (2004) theory incorporated biological evidence as support for the adaptive nature of the traumatic stress response, including how the hypothalamic-pituitary-adrenal (HPA)

axis modulates itself with the cortisol releasing system. Christopher also discussed psychosocial findings suggestive of PTG through the process of reconstructing meaning and cognitive schemas, and the role of social support in modulating biological responses.

According to Christopher,

the difference between the outcome of the normal development-inducing stress response and the pathological stress responses seems to be determined by three categories of factors needed to turn stress into adaptation and development: (a) whether the organism is sufficiently biologically healthy to make use of the resources available to it; (b) whether the cognitive schema are available to transform stress and anxiety into learning, meaning, and adaptive behavior; and (c) whether social relationships are complex, responsive, and flexible enough to adequately dampen stress arousal. (p. 77)

Christopher stated that all three categories rely on an adaptive attunement of neural networks (cognitive schema) and the endocrine system (modulates emotions) with their environment.

In a discussion about the biology of the normal stress response, Christopher (2004) noted that the psychological stress response is regulated by the HPA axis, but it begins in the amygdala which is the brain structure that processes stimuli from the senses to detect threats to the organism (Le Doux, Itwata, Cicchetti, & Reis, 1988, as cited in Christopher, 2004). This fear response can be triggered via two pathways: the “low road” which is quick, pre-rational response to threat (passes from the thalamus to the amygdala), and the “high road” which is slower, more evolved, and affected by learning, as it is modulated by the cortex rather than the amygdala.

Together these pathways create a complex fear response, as one pathway may be more adaptive than the other depending upon the environmental context of the threat.

In the case of traumatic stress, Christopher (2004) noted that Eberly, Engdahl, and Harkness (1991) argued that hypervigilance, cognitive re-simulation (the cognitive replaying of an event), and emotional dissociation are all adaptive behaviors to extreme threats, and also the behaviors seen in people diagnosed with PTSD. These behaviors may become pathological later:

(a) hypervigilance helps the individual avoid similar danger in the future because anxiety associated with the traumatic stressors is generalized to associated stimuli, (b) re-simulation enables the individual to learn from the event and develop alternative responses to possible future threat, and (c) emotional dissociation enables the person to separate emotional responses and cognitive scenarios, which clarifies the discontinuity between the high road and low road fear reactions to avoid similar mistakes and process information in new ways (Eberly et al., as cited in Christopher, 2004).

Further, due to nonexistent research specifying the biology of PTG, Christopher (2004) uses theories explaining PTSD by Pitman and associates (1987) and McFarlane and colleagues (2000) to provide a “neural/endocrine basis for understanding the far more common phenomenon of PTG” (p. 84). According to Pitman et al. (1987, as cited in Christopher, 2004), trauma results in the exaggerated response of stress hormones (neuropeptides and catecholamines), which over-consolidates traumatic memory, causing anxiety that drives the individual to generate meaning. When this memory is associated with the emotional symptoms of distress activated by the HPA axis, any reminder of the distress activates the stress reaction.

At the level of neural networks, McFarlane (2000) stated that PTSD is explained through three processes: (a) iterative learning, in which neural networks are modified during the integration of novel information, (b) pruning, or the death of neural connections that are under-utilized, and (c) top down activation, in which dominant neural networks bias or prime brain activity toward stimuli associated with certain memories. Christopher (2004) countered that because PTG is correlated with rumination only when the rumination is not dominated by self-punitive thoughts; the relationship is not a simple biologically internal process but rather is a biopsychosocial process. According to McFarlane and colleagues (2000), the iterative replaying

of the event and the cognitive and affective associations that follow is what makes a memory traumatic. Christopher argued that the normal trauma response is better understood as an evolutionary inherited mechanism for “metalearning,” which shatters and rebuilds the individual’s concept of self, society, and nature in which learning normally takes place. As such, when iterative learning and neural pruning lead to top down activation by a more coherent cognitive schema rather than a shattered one, the result is PTG, but that when top-down activation is dominated by affective neural networks that are more reactive in nature, pathology emerges.

Christopher (2004) posited that top-down domination of the traumatic memory produces increasing generalization of traumatic triggers or threat, but that this same process produces PTG when it is coupled with alternative cognitive schemas and experiences of emotional and sociocultural support. Integrating his biological and psychosocial findings, he hypothesized,

The positive effects, such as a stronger, more resilient, and more expansive conception of self, closer and more altruistic relationships with families and other significant persons, a less dogmatic approach to life, an increased willingness to accept and provide help, and increased sensitivity toward others, an increased appreciation of life, less materialistic values, and more wholistic perceptions of reality, are best understood as normal metalearning reconstitutions of the individual’s complex, subjective matrix of self, society, and nonhuman environment. (p. 86)

Conversely, he posited that the negative trauma outcomes of severe dissociation and re-experiencing of events, extreme avoidance, hyperarousal, anxiety, depression and substance use, are the results of “a failure to adequately modulate the normal adaptive trauma response with a meaningfully coherent metaframework” (p. 86).

Christopher (2004) also stated that if the goal of trauma treatment is to facilitate PTG rather than simply minimize symptoms, medication intervention should be used sparingly.

Christopher suggested that the modulating effect that psychopharmacological medication has on

the HPA axis may interfere with the normal process of neural pruning and reconfiguration that is essential to PTG. As such he recommended that the focus of intervention should be on assisting the individual to develop the metacognitive reconfiguration of schema needed to turn anxiety into meaning. He cautioned that because pharmacological treatment does not restore pre-trauma biology, if the person lacks the cognitive schema to turn traumatic stress into meaningful lessons, the endocrine changes in the HPA axis would likely continue to transform environmental novelty into maladaptive or pathological responses.

Tedeschi and Calhoun's model of PTG. Tedeschi and Calhoun's model of PTG (Tedeschi & Calhoun, 1995, 1996, 2004; Calhoun & Tedeschi, 1999, 2006) takes into account the importance of appraisal processes (Janoff-Bulman, 1992), empirical work in growth (for a review see Tedeschi & Calhoun, 2004), as well as their clinical experience working with individuals who have experienced trauma, loss, and crises (Calhoun & Tedeschi, 1999). According to Joseph and Linley (2006), Tedeschi and Calhoun (1995, 1996, 2004; Calhoun & Tedeschi, 1999, 2006) offer the most comprehensive theoretical description of growth to date. Specific elements of Tedeschi and Calhoun's (1995, 1996, 2004; Calhoun & Tedeschi, 1999, 2006) model of PTG includes the nature of the traumatic event, personality characteristics, styles of managing emotional distress that may increase the likelihood of experiencing PTG, self-disclosure of emotions related to the traumatic event and how others' responses may impact PTG, cognitive-processing including rumination/cognitive engagement, sociocultural influences, and narrative development and wisdom.

The traumatic event. Central to their model, Tedeschi and Calhoun (1995, 1996, 2004; Calhoun & Tedeschi, 1999, 2006) elucidated that it is not the trauma itself, but rather what happens in the aftermath of trauma that is responsible for PTG. More specifically, they noted

that individuals experience positive change or transformation as a result of their *struggle* with a traumatic event or highly challenging life crisis or circumstance. Although the event itself it not said to cause change, it needs to be challenging enough to the individual's assumptive world to set in motion the cognitive processing necessary for growth (Tedeschi & Calhoun, 1996).

Tedeschi and Calhoun (2004) used a metaphor of an earthquake to describe this process of struggle, "a psychologically seismic event can severely shake, threaten, or reduce to rubble many of the schematic structures that have guided understanding, decision making, and meaningfulness" (p. 5). According to Tedeschi and Calhoun (2004), cognitive processing and restructuring may be comparable to the physical rebuilding that takes place after an earthquake. New schemas are produced that incorporate the trauma and possible events in the future, resulting in the individual to be more resistant to future "shocks" or traumas.

Personality characteristics. Tedeschi and Calhoun (1996) found that personality qualities such as extraversion and openness to experience as measured by the NEO Personality Inventory (Costa & McCrae, 1992) are modestly related to PTG whereas other Big Five personality dimensions were not. Neuroticism has been negatively associated with PTG (Updegraff, Taylor, Kemeny, & Wyatt, 2002). Elements of the NEO that Tedeschi and Calhoun (1996) found to be most strongly related to the Posttraumatic Growth Inventory (PTGI) were activity, positive emotions, and openness to feelings. Tedeschi and Calhoun suggested that individuals with these three characteristics may be aware of positive emotions even in adversity and process information about these experiences producing the schema change reported in PTG. There are also modest correlations between optimism and PTGI scores, indicating that optimism and PTG may be related but distinct concepts (Tedeschi & Calhoun, 1996). Tedeschi and Calhoun suggested that people who were considered optimists may be better able to focus

attention and resources on the most important matters and disengage from uncontrollable or unsolvable problems (Aspinwall, Richter, & Hoffman, 2001).

Distressing emotions. Tedeschi and Calhoun (2004) stated that the process of growth can be lengthy, and distress that persists may be important for maximum degree of PTG to occur. Many people who survive traumatic events report that many months later they can still be struck by a sense of disbelief (Tedeschi & Calhoun, 1996). Distress keeps the cognitive processing active enough to accommodate the traumatic event, whereas a rapid resolution is probably an indication that the assumptive world was not severely tested (Tedeschi & Calhoun, 1996).

Support and disclosure. Tedeschi and Calhoun (2004) suggested that the cognitive processing of trauma into growth appears to be aided in many individuals by self-disclosure in supportive social environments. Social support may play a strong role in the development of PTG when it remains stable and consistent over time (Tedeschi & Calhoun, 2004). Tedeschi and Calhoun posited that supportive others can assist in one's PTG process by providing a way to craft narratives about the changes that have occurred as a result of the trauma, by offering perspectives that can be integrated into schema change (Neimeyer, 2001). Tedeschi and Calhoun emphasized the importance of mutual support such as support groups because it offers the trauma survivor the opportunity to incorporate new perspectives or schemas (Tedeschi & Calhoun, 1999). Tedeschi and Calhoun suggested that narratives of trauma and survival are always important in PTG, because the development of these narratives forces survivors to confront questions of meaning and how it can be reconstructed (McAdams, 1993; Neimeyer, 2001).

Rumination/cognitive engagement. Tedeschi and Calhoun (1996) posited that traumatic events serve as seismic challenges to individuals' pre-trauma schema by shattering prior goals, beliefs, and ways of managing emotional distress. Shattering leads to ruminative activity in

which individuals try to make sense of what has happened, which is often distressing but indicates the presence of cognitive activity directed at rebuilding pre-trauma schemas (Tedeschi & Calhoun, 1996). Tedeschi and Calhoun (1995, 1996, 2004; Calhoun & Tedeschi, 1999, 2006) suggested that rumination is one's attempt to integrate new trauma-related information into one's current worldview.

Calhoun and Tedeschi (2006) used Martin and Tesser's (1996) definition of rumination that refers to repeated thinking that is not necessarily intrusive, including reminiscing, problem-solving, and trying to make sense. Calhoun and Tedeschi suggested that Martin and Tesser's concept describes rumination in cognitive processing that leads trauma survivors toward growth. To eliminate confusion of "rumination" as a term implying negative or self-punitive thinking, Calhoun and Tedeschi used *cognitive engagement* as a synonymous term for Martin and Tesser's concept of rumination as it applies to PTG.

Initial rumination may be more automatic and take the form of re-experiencing and avoidance symptoms (Tedeschi & Calhoun, 2004). Comfort and relief provided by one's social support as well as using new coping behaviors, influence this ruminative process, making available the possibility of constructing new post-trauma schemas (Tedeschi & Calhoun, 2004). Successful coping at this stage facilitates disengagement from goals that are now unreachable and beliefs that are no longer maintainable in one's post-trauma environment, as well as a decrease in emotional distress (Tedeschi & Calhoun, 2004). This shift from automatic ruminative activity to more effortful ruminative activity is characterized by narrative development (Tedeschi & Calhoun, 2004).

Narrative development and wisdom. Tedeschi and Calhoun (2004) noted that as survivors reflect on the discrepancy among unattained goals or schemas, they develop the "before and

after” narrative of the trauma with the trauma as a “turning point” (McAdams, Reynolds, Lewis, Patten, & Bowman, 2001; Tedeschi & Calhoun, 1995). According to Tedeschi and Calhoun, the struggle with traumatic events can lead to a revised life story (McAdams, 1993) and to the possibility of PTG. Tedeschi and Calhoun posited that PTG appears closely connected to the development of general wisdom about life, and the development and modification of the individual’s life narrative. Tedeschi and Calhoun also suggested that part of this narrative development may be the search for meaning, and represent growthful adaptation. During this process, one may still endure distress from the trauma, but at a lower level than experienced immediately after the trauma (Tedeschi & Calhoun, 1999).

Sociocultural context. Calhoun and Tedeschi (2006) suggested that it is useful to consider both broad cultural themes at the societal level (distal culture) and small social networks and communities in which individuals interact (proximate culture) in trying to understand the process of PTG. Based on the literature on the relationship between rumination, social constraint, and psychological distress (Lepore & Helgeson, 1998), Calhoun and Tedeschi asserted that individuals with high rates of cognitive engagement with trauma-related information and a high need to self-disclose may be particularly affected by the responses received from the proximate culture. In turn, these responses may impact the content of the individual’s rumination (Calhoun & Tedeschi, 2006). Calhoun and Tedeschi expected that unsupportive responses from others might stifle one’s ability to maintain focus on reflections than can lead to PTG. They also hypothesized that when an individual’s disclosures contain themes of growth, and the proximate culture also contains themes of growth in relation to the posttraumatic stress response, growth is more likely to be experienced if responses to one’s disclosure are accepting (Calhoun & Tedeschi, 2006). Calhoun and Tedeschi also hypothesized

that PTG may occur more if the view within the culture is that struggling with trauma can change one for the better.

Maercker and Zoellner's two-component model of self-perceived PTG. The two-component model of self-perceived PTG proposed by Maercker and Zoellner (2004; Zoellner & Maercker, 2006) posited that PTG might have two sides, or *faces*. The two co-existing components in their model of PTG consist of (a) the, constructive, self-transcending side of PTG, and (b) the self-deceptive, or illusory side. More specifically, the authors stated that Tedeschi and Calhoun (1996; 2004; 2006) have written extensively about the constructive, self-transcending side of PTG, while the deceptive illusory side has been studied and referred to as positive illusions by Taylor and colleagues (Taylor, 1983; Taylor & Armor, 1996; Taylor & Brown, 1988; Taylor et al., 2000), as previously discussed.

According to Maercker and Zoellner's (2004; Zoellner & Maercker, 2006) model, the constructive side of PTG could be linked with functional adjustment or functional cognitive restructuring in the long-term and in the short-term, as it is supposed to reflect the result of active struggling with the trauma (Maercker & Zoellner, 2004). In successful coping with trauma, the constructive self-transforming component of PTG is assumed to grow over time and the illusory component is assumed to decrease over time (Maercker & Zoellner, 2004).

On the other hand, the self-deceptive side might be linked to denial, avoidance, wishful thinking, self-consolidation, or consolation, but is not necessarily associated with maladjustment (Zoellner & Maercker, 2006). Rather, the illusory component may coexist with deliberate thinking about the trauma as an active coping effort with short-term palliative functions to reduce acute stress but with neither good nor negative long-term effects (Zoellner & Maercker, 2006).

However, if the illusory component serves the function of denial and repression, such coping may result in negative long-term adjustment (Zoellner & Maercker, 2006).

Maercker and Zoellner (2004) developed their two-component model of PTG using preliminary support including qualitative and quantitative research examining PTG. Maercker (1998) first assessed PTG using a content analysis of transcriptions of interviews with former political prisoners in Germany. He explored the associations between theme categories from the content analysis and common coping strategies from the Stress and Coping Process Questionnaire (SCPQ; Reicherts & Perrez, 1992) that included items on reappraisal and items on palliation. The two SCPQ scores were considered to represent the two sides of processing threats, namely a constructive (reappraisal) side and a distractive (palliation) side. Stating personal growth in the category of changed philosophy of life was directly associated with increased scores of reappraisal and palliation. All remaining coping strategies such as blaming others or help seeking were not associated with any PTG themes. The author suggested that these findings provided a first indication of the existence of a two-component model of PTG because reappraisal and palliation represented entirely different psychological strategies and were not inter-correlated with one another. Also, there were no significant associations between PTSD symptoms and self-reported PTG (Maercker, 1998).

Using the same sample in a later study, Maercker and Langner (2001), again after establishing that there were no significant associations between PTSD symptoms and self-reported PTG, analyzed the relationships among coping strategies. The authors found that both active mastery (e.g., “It was important to me to keep my self-esteem”) and palliation, as assessed by the SCPQ, were positively correlated with the PTGI growth score, suggesting once more that

the two coping strategies represented the two sides of the two-component model: active coping for the constructive side and palliation for the illusory side (Maercker & Zoellner, 2004).

Maercker and Zoellner (2004) noted that it is still unclear why using content analysis versus self-report questionnaires differed with regard to the specific predictors of constructive coping strategies of reappraisal versus active mastery, and recommended a longitudinal study to test their model (Maercker & Zoellner, 2004), as longitudinal studies on PTG usually show positive relations with psychological adjustment (Davis, Nolen-Hoeksema, & Larson, 1998; Frazier, Conlon, & Glaser, 2001).

Summary/critique. Numerous terms and several models have been used to conceptualize the process of growth following trauma and adversity to better understand how it functions and how it impacts mental health. A summary of these terms representing the construct of growth following trauma and adversity, as well as related concepts, is critiqued. Next, similarities and limitations of PTG models are discussed. The section concludes with specific criticisms of Tedeschi and Calhoun's model of PTG.

Constructs of growth. The construct of growth following trauma and adversity has been critiqued. Terms that were reviewed include adversarial growth, perceived benefits, stress-related growth, thriving, benefit-finding, heightened existential awareness, positive by-products, positive illusions, and posttraumatic growth (PTG), as well as the related concepts of resilience, hardiness, optimism, and positive emotions. While these terms may have somewhat different implications, many of these concepts appear to overlap. First, adversarial growth, perceived benefits, positive by-products, and thriving define growth as positive changes following adverse or traumatic events. Second, benefit finding and heightened existential awareness describe positive benefits following adversity related to severe medical problems.

However, differences also exist among some of the terms. First, stress-related growth defines positive changes resulting from events that are stressful, but not necessarily shattering assumptions or violating one's existing way of making sense of one's self and the world, as the term PTG describes. Second, Taylor and colleagues (2000) raised the question whether PTG reflects genuine positive changes as indicated by Tedeschi and Calhoun (1996), or a coping process consisting of positive illusions (Taylor et al., 2000). Third, although the related concepts of resilience, hardiness, optimism, and positive emotions share similarities with constructs describing growth following trauma and adversity in that they describe processes of how individuals may come to perceive, respond, or cope with adverse and traumatic experiences, these concepts do not necessarily define a transformational process that moves an individual beyond pre-trauma levels of functioning as indicated by growth terminology.

Models of PTG. The PTG models reviewed include the functional-descriptive model of PTG (Tedeschi & Calhoun, 1995; 1996; 2004; Calhoun & Tedeschi, 1999, 2006), organismic valuing theory of growth through adversity (Joseph & Linley, 2005), biopsychosocial-evolutionary view of traumatic stress and growth (Christopher, 2004) and the two-component model of PTG (Maercker & Zoellner, 2004; Zoellner & Maercker, 2006). The four models of PTG are similar in that they emphasize that PTG arises through the reorganization and redevelopment of ways of thinking following a trauma or adverse event. They also posit that the breakdown of existing views of the world activates the rebuilding of more effective worldviews.

These models also appear to be complementary in that they explain different components of the PTG process. As such, Joseph and Linley's model (2005) incorporated the organism valuing process, emphasizing the role of an individual's social environment in meeting one's psychological needs for autonomy, competence, and relatedness necessary to facilitate one's

growth process, and thus modify one's existing views of the world to positively accommodate new trauma-related information. Christopher's (2004) perspective provided the biological underpinnings of the traumatic stress response and how growth may be facilitated. In addition to recommending facilitating the neural pruning necessary as means to promote PTG described by Christopher's model, Fortune and colleagues (2005) also suggested that clinicians use cognitive behavioral therapy (CBT). However, since CBT involves cognitive processing, their recommendation appears to support using Tedeschi and Calhoun's model to promote PTG as well. Tedeschi and Calhoun's (1995, 1996, 2004; Calhoun & Tedeschi, 1999, 2006) model emphasized the importance of rumination in cognitive processing, but does not acknowledge the biological processes involved in the traumatic stress response.

Additionally, none of these models conceptualized how complex trauma or DTD might impact the PTG process, especially as it relates to experiences of multiple, chronic traumas during critical periods of brain development that have been posited to impact personality development, attachment security, and self-regulation (Ford & Courtois, 2009). Thus far, theories of PTG have addressed mostly traumatic events that are synonymous with those associated with a diagnosis of PTSD.

Maercker and Zoellner's (2004; Zoellner & Maercker, 2006) two-component model illuminated both the transcending, functional component of PTG proposed by Tedeschi and Calhoun (1996) as well as the illusory nature that may serve as a temporary coping mechanism that potentially contributes to long-term maladjustment, as proposed by Taylor and colleagues' notion of positive illusions (Taylor, 1983; Taylor & Armor, 1996; Taylor & Brown, 1988; Taylor et al., 2000). Though developed using empirical support as its foundation, Maercker and Zoellner's (2004; Zoellner & Maercker, 2006) model has not yet been empirically tested. It is a

valuable contribution to the PTG literature however, as it expands upon Tedeschi and Calhoun's model by lending support to Taylor's positive illusions as a possible component or face of PTG that had been previously criticized in the literature as not being *actual* growth.

Lastly, unlike the other three models, Tedeschi and Calhoun (2004; Calhoun & Tedeschi, 2006) incorporated literature related to narrative development, wisdom, and sociocultural context in their model as possible avenues of searching for meaning and facilitating PTG. Their model also yielded the most widely used psychometrically validated measure of growth following adversity and trauma (Frazier et al., 2009), as well as a clinician's guide that offers clinical strategies for potentially facilitating PTG with clients in psychotherapy (Calhoun & Tedeschi, 1999).

Criticisms of Tedeschi and Calhoun's model. While a significant body of work has supported Tedeschi and Calhoun's (1995, 1996, 2004; Calhoun & Tedeschi, 1999, 2006) hypothesized model for PTG (Tedeschi & Kilmer, 2005), several criticisms exist including the exclusion of positive events as a source of growth (Aldwin & Levenson, 2004), lacking operational definitions for components of their model (Maercker & Zoellner, 2004) and overemphasizing the role of cognitive processing while minimizing the role of social support in the PTG process (McMillen, 2004).

First, Aldwin and Levenson (2004) suggested that Tedeschi and Calhoun's model of PTG underestimates the developmental potential of positive events such as childbirth, marriage, or profound religious experiences that may have the potential to promote growth in a dramatic way (Aldwin & Levenson, 2004). Second, Maercker and Zoellner (2004) also criticized Tedeschi and Calhoun's model asserting that constructs and psychological processes such as rumination, schema change, and narrative development may be very difficult, if not impossible, to

operationalize. Maercker and Zoellner suggested that this difficulty in identifying operational definitions for these components of the model does not allow for direct empirical testing.

Third, McMillen (2004) suggested that Tedeschi and Calhoun rely too heavily on cognitive processing and understate the role of the larger environment in their model of PTG. More specifically, McMillen recommended focusing on increasing the specificity of the role that supportive others play in facilitating PTG. Currently, Calhoun and Tedeschi's (2006) model suggests that the importance of social relationships to PTG lies in individuals' abilities to promote rumination and thus the revision of schemas. However, McMillen suggested that there may be other ways in which social support may directly facilitate the development of positive changes. For example, social support may contribute more directly to the recognition of PTG by fostering views of personal strength, as supportive others may communicate positive messages about how an individual is handling his or her experience of crisis or trauma (McMillen, 2004). In turn, receiving positive messages through social support may also remind individuals of the importance of family and friends, and of the goodness of others (McMillen, 2004). Further, a compassionate response may be modeled by supportive others, allowing the individual experiencing adversity or trauma to call on these skills if needed in the future (McMillen, 2004). Hence McMillen suggested that the cognitive focus of Tedeschi and Calhoun's model overlooks the possible contributions of these larger systems of support to fostering PTG.

Assessing PTG

Comprehensive and valid measurement strategies are recommended to capture the phenomenon of PTG (Park & Lechner, 2006). Researchers have attempted to understand PTG by using quantitative and qualitative research methodologies (Zoellner & Maercker, 2006). Both methods have their strengths and weaknesses, which will be discussed.

Qualitative methods. To assess PTG, qualitative studies have employed a number of formats. First, interviews typically use open-ended questions targeting (a) ways in which people's lives have changed as result of their trauma, and (b) positive life changes or benefits resulting from their experience of trauma (Park & Lechner, 2006; Zoellner & Maercker, 2006). Interview techniques have been used to study PTG in a variety of populations, including female survivors of abuse, women with HIV/AIDS, and female survivors of rape (Park & Lechner, 2006). Other qualitative studies have employed the life-story technique, and focus groups to study PTG (for a review, see Linley & Joseph, 2004). Additionally, Bower, Kemeny, Taylor and Fahey (2003) used an expressive writing paradigm to measure growth by deriving themes of positive meaning from participants' written disclosures about relatives they lost to breast cancer.

Studying PTG using qualitative approaches may have several advantages and disadvantages. One primary advantage is that quantitative questionnaires cannot capture all of the domains of PTG (McMillen, 2004), whereas qualitative approaches may have more flexibility in exploring possible domains by analyzing participants' descriptions of their experiences of growth. In their review of studies of PTG, Zoellner and Maercker (2006) noted that qualitative studies often simultaneously assess both negative and positive life changes, and participant responses are often categorized into domains of PTG using post hoc analyses (Zoellner & Maercker, 2006). This process may encounter potential bias however, as post hoc analyses may be guided by authors' use of various definitions of growth already found in the research literature. Park and Lechner (2006) also noted that a criticism of employing qualitative studies using interview questions is that the positive wording of questions may create bias in participants' responses. Coding and analyzing qualitative data may also be time consuming, and may not be feasible for conducting studies with large samples of individuals. Despite these

criticisms, researchers can use qualitative data to identify the content of psychometric assessment items that can be used in quantitative research of PTG (Park & Lechner, 2006).

Quantitative methods. Quantitative studies have primarily used self-report instruments as measures of growth among individuals who have experienced trauma and adversity. Unlike qualitative studies, quantitative measurement allows researchers to conduct larger-scale studies with a variety of populations to advance the understanding of growth following trauma and crises (Park & Lechner, 2006). Published self-report measures that have been used to assess positive changes following stressors, trauma, and chronic illnesses include the *Posttraumatic Growth Inventory* (PTGI; Tedeschi & Calhoun, 1996), *Stress-Related Growth Scale* (SRGS; Park, Cohen, & Murch, 1996), *Changes in Outlook Questionnaire* (CiOQ; Joseph, Williams, & Yule, 1993), *Perceived Benefits Scale* (PBS; McMillen & Fisher, 1998), and the *Thriving Scale* (TS; Abraido-Lanza et al., 1998). These measures inquire about various positive changes and provide a Likert scale format in which the participant selects one option from a number of response choices such as those that range from *not at all* to *very much*. Because the PTGI is the most widely used indicator of PTG (Frazier, Tennen, Gavian, Park, Tomich, & Tashiro, 2009), it is described next.

PTGI. The PTGI, included in the American Psychological Association's (2004) national public education campaign "the Road to Resilience," is an instrument used for assessing positive outcomes reported by individuals who have experienced traumatic events (Frazier et al., 2009). It was standardized and validated using a university sample of individuals experiencing a variety of crises or trauma (Tedeschi & Calhoun, 1996), and, to date, appears to be the only published measure of growth following adversity that has been translated for use with several non-English speaking populations (i.e., Bosnian, Chinese, Japanese, Turkish, German, Spanish, and Hebrew).

In their development of the PTGI, Tedeschi and Calhoun (1996) identified three broad categories of PTG that were determined based on their review of the literature and interviews with individuals who experienced trauma and crises: (a) changes in the perception of self, (b) changes in the experience of relationships with others, and (c) changes in one's general philosophy of life. According to Sheikh (2008), a commonality across these areas of growth is that they each involve active engagement and openness to change. The broad categories of PTG are described.

Changed sense of self. A common negative psychological consequence of trauma is an individual's increased sense that the world is an unsafe place (Janoff-Bulman, 1992). This notion that the world is an unsafe place can produce recurring feelings of fear and anxiety, but it can also increase one's sense of vulnerability (Tedeschi & Calhoun, 1996). Following a traumatic event or crisis, an individual's successfully meeting numerous specific demands can greatly enhance one's sense of personal strength. Some individuals who have faced negative events may develop a strengthened sense of competence in meeting future life demands (Calhoun & Tedeschi, 1999).

Changed sense of relationships with others. According to Tedeschi and Calhoun (1996), this greater sense of closeness with others following adversity elicits greater freedom to make self-disclosure. Individuals reporting PTG in this area regard their increased capability in self-disclosure as positive. Individuals can experience an increased need to talk about and discuss their situations in the wake of trauma, making self-disclosure easier and more satisfying (Tedeschi & Calhoun, 1996). An increased sense of freedom in emotional expressiveness can be a manifestation of PTG in individuals who experience major life crises. Tedeschi and Calhoun noted that an encounter with suffering can lead people to be more honest about what they really

think, feel, and feel a greater ease in expressing themselves emotionally with others. These individuals may also experience increased empathy and compassion for other persons facing crises. They may also be more likely to help others in their increased sensitivity to the suffering of others.

Changed philosophy of life. When an individual experiences traumatic stress, the confrontation with death can lead to a greater appreciation of the value of everyday things (Tedeschi & Calhoun, 1996; Yalom, 1991). A common manifestation of PTG is a greater appreciation of one's life (Tedeschi & Calhoun, 1995). There can also be a shift in life priorities. In the United States, many individuals may experience growth as a changing in spiritual or religious beliefs, and a deepening of one's existential experience in a positive way (Calhoun & Tedeschi, 1999; Tedeschi & Calhoun, 2006). Initially individuals may experience a loss of faith or question their religious beliefs, but report that beliefs changed in a positive way (Calhoun, Tedeschi, & Lincourt, 1992). Beliefs may change in a positive way, or may become stronger resulting in an increased involvement in organized religion (Calhoun & Tedeschi, 1999).

PTGI description. To develop the PTGI, Tedeschi and Calhoun (1996) subjected the three broad categories of PTG to a factor analysis, yielding five dimensions or subscales: *relating to others, new possibilities, personal strength, spiritual change, and appreciation of life* (Tedeschi & Calhoun, 1996). The PTGI produced a total score as well as scores on the five subscales and has good reliability and validity (Tedeschi & Calhoun, 1996). The full-scale alpha for a sample of undergraduate students was .90, and the subscales' coefficients ranged from .67 to .85 (Tedeschi & Calhoun, 1996). The PTGI is considered to have good internal consistency, acceptable test-retest reliability, and scores on the scales are approximately normally distributed among persons reporting a variety of life traumas (Tedeschi & Calhoun, 1996). The PTGI has

been translated into Bosnian (Powell, Rosner, Butollo, Tedeschi, & Calhoun, 2003), Chinese (Ho et al., 2004), Turkish (Kilik, 2005, as cited in Dirik & Karanci, 2008), German (Maercker & Zoellner, 2004), Spanish (Weiss & Berger, 2006), Hebrew (Lev-Wiesel & Amir, 2003), and Japanese (Taku et al., 2007). Of the published measures of growth following traumatic experiences, the PTGI has the best documented psychometric properties and best captures the multidimensional quality of PTG (Weiss & Berger, 2006).

Criticisms of self-report measures. Authors have questioned the validity of self-report measures of growth for several reasons. Criticisms of validity include (a) the samples in which assessment measures were normed, (b) item content and response choices, (c) measuring the construct of growth as actual growth versus perceived change, (d) using corroborated reports of growth, and (e) cultural implications related to construct validity.

Normative samples. Few growth scales have been subjected to psychometric validation procedures (Park & Lechner, 2006). The PTGI, SRGS, and BFS are the only psychometrically validated measures currently in use (Park & Lechner, 2006). None of these measures have been validated on more than one population, as the PTGI and SRGS were validated using college samples, and the BFS was validated using breast cancer patients (Park & Lechner, 2006). As a result they may or may not adequately assess dimensions of growth that are specific to other populations (Park & Lechner, 2006). Still, Tedeschi and Calhoun (1996) argued that college students are comparable to the general population in terms of experience with trauma by referencing work by Vrana and Lauterbach (1994) that demonstrated that male and female Caucasian individuals in a predominantly middle-class university sample reported a high prevalence of traumatic experiences and multiple traumatic events. Nonetheless, Park, Cohen, and Murch (1996) suggested in their development of the SRGS that future research using their

growth measure should include a sample of community adults. Thus it may prove beneficial to norm a self-report measure of PTG using ethnically/racially diverse individuals, such as in urban communities. Researchers and clinicians may then be better able to accurately assess PTG among racial/ethnic minority individuals, who are more frequently exposed to traumatic stress than non-minority individuals, as previously discussed.

Content validity. Positive change may also occur in domains that are not assessed by current growth scales. For example, using a qualitative interview approach, Siegel and Schrimshaw (2000) identified positive change among a sample of Puerto Rican, African American, and Caucasian women with HIV, including positive health behaviors not included in a dimension of positive change assessed by any of the current growth scales (Park & Lechner, 2006). Also, as all of the measures previously described have been developed on the basis of their authors' conceptualizations of growth following trauma and adversity, there is no standard definition for what constitutes growth that may guide item selection for measurement development (Joseph, Linley, & Harris, 2005).

The possibilities of response choices provided on self-report measures of PTG may also create bias in whether and how individuals endorse positive change or growth (Frazier, Oishi, & Steger, 2003; Park & Lechner, 2006). Self-report inventories such as the PTGI and SRGS do not allow respondents to report negative aspects of trauma (Frazier et al., 2003). Frazier et al. suggested that respondents may develop a *positivity response bias* and report positive change when none has occurred, or not report changes about which they are not asked.

Calhoun and Tedeschi (2006) countered this notion of a positivity response bias by arguing that there is no evidence that the content and structure of the current scales lead to the false positive report of growth, supported by literature that suggests (a) the PTGI is not

correlated with measures of social desirability, (b) respondents may actually underreport growth on growth scales, (c) respondents report PTG along with highly negative psychological states, and (d) self-reported growth tends to be corroborated by others (see McMillen & Cook, 2003; Park, 1998; Park, Cohen, & Murch, 1996; Smith & Cook, 2004; Tedeschi & Calhoun, 2004; Wild & Paivio, 2003). Calhoun and Tedeschi (2006) recommended including established measures of negative posttraumatic responses (e.g., General Health Questionnaire [GHQ; Goldberg, 1972], Impact of Event Scale [IES; Horowitz, Wilner, & Alvarez, 1979]) along with measures of growth as a way to measure negative changes (Tedeschi & Calhoun, 2006). Additionally, qualitative studies can provide a way to study or measure one's subjective experience of suffering and self-perceived changes.

Construct validity. In their review of psychological assessment measures of growth following adversity, Joseph and Linley (2008) suggested that the psychometric properties of the published self-report measures of growth appear adequate and appear to have substantial conceptual and empirical overlap. However, because they are not necessarily interchangeable, Joseph and Linley recommended that researchers and clinicians employ a battery of measures whenever possible.

Empirically establishing the validity of growth as a construct distinct from other psychological processes, resulting in possibly inaccurate reports of growth, is also a difficult aspect of assessing PTG in self-report measures (Lechner & Antoni, 2004). Park and Lechner (2006) noted that while these measures are extremely useful in helping researchers to understand the phenomenon of growth, it is important to note that they are retrospective measures of perceived change, in which participants are asked to compare their current functioning to previous levels of functioning. As such, self-report measures of personal change have been

questioned due to the notion of PTG relying on recalled experience (Nolen-Hoeksema & Davis 2004), as individuals may not be very accurate in assessing the degree to which they have changed over time or experienced growth (Tennen & Affleck, 2005). People may consciously or unconsciously report growth that is not factual, through processes such as social desirability, cognitive bias, self-enhancement, and underestimating past functioning to inflate current one's functioning (Wortman, 2004). This may be problematic to the validation of self-report inventories because individuals may respond in a manner due to their desire to perceive themselves as continually growing or self-actualizing (McFarland & Alvaro, 2000).

Further complicating the measurement of the growth construct in self-report inventories is data that suggests that perceived changes in personal attributes may be weak predictors of prospective data documenting actual change (Robins, Nofle, Trzesniwski, & Roberts, 2005). Actual change in this study was defined as changes in individuals' scores on a standardized personality measure, the NEO-Five Factor Inventory (NEO-FFI; Costa & McCrae, 1992), while perceived growth was defined as individuals' self ratings of how much they thought they had changed on each of the Big Five dimensions since the last time they were assessed using the NEO-FFI.

To investigate the matter further, Frazier et al. (2009) questioned whether an individual's ability to accurately recall personal and relationship change when measured retrospectively reflects change that is described theoretically and clinically. Using a prospective study design, Frazier et al. compared the difference between pre- and post-trauma indicators of perceived growth and actual growth. They asked participants to respond to the PTGI two months post-trauma as a measure of *perceived growth*, and measured *actual growth* by having participants respond to a "current standing" of the PTGI (items were phrased to reflect the past two weeks) at

the time of the trauma as well as two months post-trauma. They concluded from their findings that the PTGI and other retrospective measures did not appear to measure actual pre- to post-trauma change because they found that PTGI scores were unrelated to actual growth in posttraumatic growth-related domains. However, their data also suggested that perceived growth was associated with increased distress from pre-to post trauma, whereas actual growth was related to decreased distress, suggesting that perceived and actual growth reflect different processes. A limitation of this study is that the time measuring pre-to post trauma may have been too soon, as it was only eight weeks. Tedeschi and Calhoun (1995) posited that growth takes time to emerge, although they do not provide specific time windows. Frazier et al. suggested that perhaps PTG is a coping strategy soon after a trauma, but subsequently is transformed into actual growth. As such, this study does not appear to provide strong support for its finding that PTGI scores were unrelated to actual growth.

Additionally, researchers have attempted to demonstrate the validity of the growth construct as assessed in self-report measures by relying on informant reports of growth, examining changes in psychosocial resources across time, and examining growth in the context of adjustment (Park & Lechner, 2006). For example, Weiss (2002) found moderately strong relations between self-reports and informant reports of growth among a predominantly upper-middle class sample of survivors of breast cancer and their husbands from Long Island, New York (race or ethnicity was not specified).

Cultural implications. Because culture is a lens through which individuals perceive and interpret the world and create meaning (Hooyman & Kiyak, 2005), translation of an instrument into a different language could yield a culture-specific factor structure (Weiss & Berger, 2006).

Also, cross-cultural differences in the experience and expression of growth may yield different dimensions of growth indicated on self-report measures.

More specifically, these notions may be supported by several studies that developed various translations of Tedeschi and Calhoun's (1996) PTGI, as well in developing the TS by Abraido-Lanza and colleagues (1998), an English measure applied with a culturally diverse sample of impoverished Latinas with chronic illness. In a three-year longitudinal study exploring factors that promoted thriving among Latinas using the TS, Abraido-Lanza and colleagues demonstrated that *patience* or taking one day at a time emerged as one of the primary dimensions of growth. The authors suggested that this might have been a function of the cultural group, as patience was not identified in the university samples used to construct the PTGI and SRGS (Abraido-Lanza et al., 1998). Additionally, using a translated version of the PTGI in their study of Chinese cancer survivors, Ho et al. (2004) could not find a distinct dimension of emotional change, which they hypothesized may have been due to a tendency in Chinese culture to focus less on emotional experiences or on the integrated mind-body relationship. Their result suggests that the emotional dimension (i.e., individuals being more aware of their own feelings) of self-report growth measures may be more culturally bounded (Ho et al., 2004).

Further, Weiss and Berger (2006) attempted to adapt and validate a Spanish translation of the PTGI using a sample of Spanish-speaking Latina immigrants in the United States. Although a factor analysis failed to replicate the original five factors identified in Tedeschi and Calhoun's (1996) PTGI, the three factors identified, *relating to others*, *new possibilities*, and *personal strength*, were consistent with the conceptual underpinnings of the original PTGI (Weiss & Berger, 2006). The *philosophy of life* factor in the Spanish translation of the PTGI was primarily a combination of the original (English) PTGI's *spiritual change* and *appreciation of life*

subscales, the *self-positive life attitude* factor combined the original subscales of *personal strength* and *new possibilities*, and the *interpersonal relationships* factor was a partial replication of the original *relating to others* subscale (Weiss & Berger, 2006). Thus one original PTGI factor was identified in the Spanish translation, whereas the other original factors were combined into new factors on the Spanish translation of the PTGI (Weiss & Berger, 2006). Weiss and Berger suggested that these findings are consistent with the central role of religiosity and spirituality in Latino and Bosnian cultures.

The failure to fully replicate the original five-factor structure found empirically by Tedeschi and Calhoun (1996) in the original PTGI is consistent across all translated versions (Weiss & Berger, 2006). The German (Maercker & Langner, 2001) and Chinese (Ho et al., 2004) studies found four-factor structures whereas the Bosnian (Powell et al., 2003) found a three-factor structure similar to that of the Spanish translation (Weiss & Berger, 2006). Additionally, the Japanese version (Taku et al., 2007) replicated three of Tedeschi and Calhoun's (1996) original five factors: *relating to others*, *new possibilities*, and *personal strength*, and a fourth factor integrating *spiritual change* and *appreciation of life*. Further, some factors in the German and Chinese translations have a partial resemblance to the Spanish and Bosnian factors (Weiss & Berger, 2006). Though different from Tedeschi and Calhoun's empirical factor structure, the three-factor structures found in the Spanish and Bosnian translations are compatible with the three broad domains of growth that Tedeschi and Calhoun originally conceptualized (*changed sense of self*, *changed interpersonal relationships*, and *changed philosophy of life*) and from which they derived their five-factor structure (Weiss & Berger, 2006).

Weiss and Berger (2006) suggested that a possible explanation for different translations of the PTGI yielding different factor structures is related to cultural differences relative to individualism versus collectivism. American culture is highly individualistic and places strong emphasis on personal accomplishments, self-fulfillment, and happiness (Weiss & Berger, 2006). In contrast, Bosnian and Latino cultures are familistic or collectivist and place strong emphasis on relationships with extended family and intergenerational commitments, and East German and Chinese cultures are also more collectivist than American culture (Weiss & Berger, 2006). Consequently, one's personal experiences and perceptions of strengths, including recognition of new possibilities in life, are filtered and interpreted through a familial lens (Weiss & Berger, 2006).

Facilitating Posttraumatic Growth in Psychotherapy

Several authors suggested recommendations for promoting growth following trauma (Bannink, 2008; Briere & Scott, 2006; Calhoun & Tedeschi, 1999; O'Hanlon, 1999) and others asserted that growth or finding benefits resulted after using specific treatment interventions (Lechner & Antoni, 2004). Lechner and Antoni (2004) noted that interventions that specifically aim to promote PTG are scarce in the literature. Interventions and recommendations noted in the literature for promoting growth following crisis and trauma are discussed next.

Interventions. Calhoun and Tedeschi (1999) noted that group settings can be helpful in promoting PTG based on their own clinical experiences facilitating bereaved parent support groups. For example, Antoni and colleagues (2001) developed and tested a cognitive-behavioral stress management (CBSM) group intervention, which they found promoted benefit-finding in women who were recently diagnosed and treated for breast cancer, though this was not the original intention of the group therapy intervention. More specifically, involving a sample of

women with 0-2 stage breast cancer with no prior psychiatric history recruited from several hospitals in Miami Florida (age and ethnicity were not specified), Antoni and colleagues used the CBSM intervention to teach behavioral and cognitive strategies in a supportive group setting, which encouraged women to role-play strategies such as coping skills, expressing feelings, promoting hope, and preserving social support (Antoni et al., 2001). Lechner and Antoni (2004; Antoni et al., 2001) suggested that although the intervention was not specifically designed to enhance PTG but rather to reduce symptoms such as depression and intrusive thoughts, they hypothesized that it might promote growth based on support from Tedeschi and Calhoun's (1996) literature supporting reports of growth following trauma. Although Antoni and colleagues cited Tedeschi and Calhoun's model of PTG in their literature review, they did not use the PTGI or a similar self-report measure of growth in their population of female cancer survivors. Rather, they used a scale that measures perceptions of benefit finding among parents with children with special needs. Nevertheless, they found that participants in the CBSM intervention condition showed a significant increase in benefit finding at post-intervention as compared to the control group. They also found increased reports of optimism, as measured by the Life Orientation Test-Revised (LOT-R; Scheier, Carver, & Bridges, 1994).

Recommendations. Solution-focused therapists such as Bannink (2008) and O'Hanlon (1999) provided suggestions for promoting posttraumatic success with clients in psychotherapy, Calhoun and Tedeschi (1999) also published counseling strategies as recommendations for facilitating PTG in psychotherapy, and Briere and Scott (2006) also recommended ways for therapists to reframe trauma as challenge to promote growth following trauma. In Bannink's discussion of what individuals do to survive and what makes them strong, he suggested exploring client's resilience by asking them in detail about the times they did not experience the

problem when they expected that they would, find out what happens as the problem ends or starts to fade, ask why the problem is not worse, and facilitate discussion about the client's past success stories. Further, he noted that solution-focused brief therapy (SFBT) approaches trauma differently than traditional forms of psychotherapy in that it focuses on the preferred future and the steps clients can take to reach this future. Research by Stams, Dekovic, Buist, and de Vries (2006) supported that SFBT had a positive effect on individuals receiving a shorter length of treatment, as compared to individuals in studies involving longer durations of treatment.

O'Hanlon (1999) provided guidelines for promoting posttraumatic success in therapy with survivors, including to (a) inquire about what the client is seeking to gain from treatment and how he or she will know when the treatment has been successful, (b) promote the client's feeling of safety, including using provisions such as contracts for safety from suicide or potentially dangerous situations, (c) do not assume that the client needs to go back and work through traumatic memories, (d) look for resources and strengths, including healthy relationships and current skills (e) validate and support the client's experience, (f) stay focused on the goal of treatment, (g) do not give the impression that the client is "damaged" or that one's future is determined by the trauma, and (h) challenge self-blaming or invalidating narratives about one's identity. Of note, these guidelines have not yet been empirically tested.

Briere and Scott (2006) noted that it is beneficial for therapists to have the perspective of posttraumatic symptoms as adaptive and recovery-focused in an attempt to resolve distressing thoughts, feelings and memories, rather than as pathological. They also suggested that trauma can result in not only recovery but growth by gaining in some way from the traumatic experience. According to Briere and Scott, therapists can reframe trauma as challenge, pain (in part) as awareness and growth, and the future as opportunity, while at same time acknowledging

client's experiences and distress. The client may not completely believe the therapist's positive appraisal of him or her; however, visible therapist respect assists greatly in establishing a therapeutic rapport, increasing the likelihood that the client will make him or herself psychologically available to the therapeutic process (Briere & Scott, 2006).

Calhoun and Tedeschi's (1999) counseling strategies for facilitating PTG in psychotherapy can be applied to individual, group, couples and family therapy. Their recommendations have also been noted as ways in which clinicians can assess the presence of PTG in psychotherapy (Tedeschi & Kilmer, 2005). Sheikh (2008) recapitulated Calhoun and Tedeschi's recommended counseling strategies in her review of PTG and possible implications for counseling practice. Calhoun and Tedeschi developed recommendations for facilitating PTG in psychotherapy from their own clinical experience working in the field of trauma. They believe that until survivors of a major life crisis or trauma can successfully construct meaningful personal narratives that organize information about themselves (McAdams, 1993) and the trauma, growth may be experienced as tentative and fleeting.

Calhoun and Tedeschi (1999) recommended five general counseling strategies that therapists can use to encourage growth, including (a) focusing on listening without trying to solve, (b) noticing growth as the client approaches it, (c) labeling growth when the client makes references to it, (d) broaching the topic of posttraumatic growth related to events in which the client perceives growth as not possible, and (e) choosing the right words to reflect growth to the client. At the same time, they remind clinicians that they cannot create growth for their clients, but rather can help clients to find growth when it has the potential to occur (Calhoun & Tedeschi, 1999). Calhoun and Tedeschi's recommended counseling strategies for facilitating PTG are described next.

Focus on listening, without necessarily trying to solve. Calhoun and Tedeschi (1999) suggested that the first step will typically occur after the initial stages of treatment wherein distress has been reduced and the client has learned some coping skills. They recommended that the therapist should be fully present with the client and maintain a high degree of comfort while enduring the client's disclosure of painful and traumatic stories. The therapist should express empathy without disrupting the client's telling of his or her story or the client's displayed affect. Calhoun and Tedeschi cautioned that even though beginning clinicians are tempted to provide solutions or advice, they should refrain from doing so in an effort to listen to the accounts and narratives the client develops for two reasons. First, PTG may be most visible to the therapist during these accounts. Second, therapist can examine the effects of trauma on fundamental beliefs and how the client perceives the self and the world, rather than purely trying to relieve the client's distress. In doing so, therapists who can listen to the distress open the possibility of learning from their clients (Calhoun & Tedeschi, 1999)

Notice growth as the client approaches it. Calhoun and Tedeschi (1999) stressed that therapists try to perceive PTG as the client begins to consider it as a possibility, which is revealed primarily through verbal exchanges. A therapist must listen and bring into focus growth that is implicit in the client's account. From the authors' understanding, precursors or "positive signs" that signal implicit growth include (a) the distressing struggle to understand what a trauma will do to one's life, (b) how life can be in the aftermath of the trauma, and (c) the distress of not believing or understanding things. Calhoun and Tedeschi described this process of bringing growth into focus as an internal process of the therapist looking beyond the meaning of words to see the larger pattern of struggle, which requires the clinician to have an emotionally

open stance, thereby “listening with the third ear” (Reik, 1948, as cited in Calhoun & Tedeschi, 1999).

Label it when it is there. Calhoun and Tedeschi (1999) advised that the therapist should acknowledge and reinforce when the client makes reasonable positive interpretations of growth coming from the struggle with trauma. As the client begins to articulate positive changes into the account of the event or in the narrative of his or her life, the therapist can label these changes that the client identifies as already present, or reframe the way the individual views certain events. Calhoun and Tedeschi cautioned that the therapist “must guard against offering platitudes about what wonderful opportunities crises are” (p. 64) and instead listen carefully and provide support while the client articulates his or her experience of positive change.

In addition, therapists should ensure that attempts to reinforce, label, or bring growth into focus are timed well. Calhoun and Tedeschi (1999) recommended that it is not a good time to focus on PTG (a) in the immediate aftermath of a traumatic event, (b) when events are still overwhelming and the client needs help with basic coping, and (c) when the client views his or her particular loss as “repellent and incomprehensible” (p. 65), as the client may interpret the experience of growth as a sign of disloyalty or a lack of moral principle. Calhoun and Tedeschi suggested that even when events are tragic, the therapist should remain attuned to the possibility of growth and bring it into focus for the client when the client’s own account provides evidence that growth may be occurring.

Events that are too horrible. Calhoun and Tedeschi (1999) advised that therapists should always follow the lead provided by their clients’ description of their experiences. A therapist can examine a client’s willingness to think about his or her experience in terms of PTG by asking the following: “Some people I’ve worked with have said that they have changed in some positive

ways as they coped with their trauma. Do you think that is possible for you, given the kinds of things you went through?” (p. 66). Calhoun and Tedeschi cautioned that although many clients will provide evidence of PTG, therapists should remember that growth is not universal or inevitable for their clients who have suffered a trauma.

Choosing the right words. Calhoun and Tedeschi (1999) stressed the importance of the words that therapists choose to label or identify PTG. They emphasize that word choices need to reflect that growth is not produced by the traumatic event, but by the individual’s *struggle* to survive and come to terms with what happened. The authors provided the following example: “Your *struggle* with the pain produced by Joey’s loss has led you to be more committed to helping others to avoid your kind of pain.” In contrast, they give an example of what not to say, “Joey’s death led you to be more committed to helping others avoid your kind of pain.”

Critique. Despite their strengths, Calhoun and Tedeschi’s (1999) counseling strategies for facilitating PTG in psychotherapy have some limitations. First, Calhoun and Tedeschi’s strategies have not yet been empirically tested. Yet, some of their strategies are similar to widely used and empirically supported counseling techniques. For example, the strategy *Focus on listening without necessarily trying to solve* is similar to reflective listening (Rogers, 1951), a cornerstone of Rogerian nondirective counseling, also known as person-centered therapy. The recommendation *Notice growth as the client approaches it* was also derived from Reik’s (1948) theory of psychoanalytic listening (Calhoun & Tedeschi, 1999). Further, because Calhoun and Tedeschi suggested that their clinical intervention “may best be viewed as a continual process of narrative development” (p. 60), particularly with their PTG model emphasizing cognitive processing, their goal in facilitating PTG in psychotherapy appears similar to that of cognitive behavioral therapies and narrative therapies (i.e., Malkinson, 2007; Meichenbaum, 2006;

Neimeyer, 2001), in which the aim is to assist the client to reconstruct one's shattered story in an effort to construct a new meaning to life or narrative.

Another limitation of Calhoun and Tedeschi's (1999) counseling strategy *Label it when it is there* is that it provides more guidance on what *not* to do to label growth, as opposed to *how* to do it. Although their guidance in this recommendation is helpful as they provide several examples of when not to label growth, it would benefit therapists using their strategies to have access to more suggestions of how to label growth.

As for the recommendation addressing *Events that are too horrible*, Calhoun and Tedeschi (1999) do not expand any further regarding what the therapist should do if the client says "no" to the therapist's question asking if he or she thinks growth is possible. As such, this recommendation appears to be positively biased, as it seems to assume that individuals usually answer "yes." Based on Calhoun and Tedeschi's stance that the clinician should always keep in mind that growth is possible, therapists can likely speculate that if a client said "no," Calhoun and Tedeschi would advise to revisit the subject later in treatment when the client articulates positive changes.

Though Calhoun and Tedeschi (1999) described their strategies as general guidelines in working with individuals who have experienced a broad spectrum of traumatic and distressing events, they did not address potential differences that may arise in using these strategies with clients of different cultural and ethnic backgrounds. In fact, Calhoun and Tedeschi did not address potential cultural differences in the process of PTG until they were criticized by other authors for lacking attention to culture in their PTG model, and subsequently addressed it later in their 2006 *Handbook of Posttraumatic Growth*. However, Calhoun and Tedeschi (2006) still did not specifically address how these cultural differences may impact therapists' use of their five

counseling strategies. It would have been helpful for Calhoun and Tedeschi to include the recommendation that counselors should be aware that growth might arise within a specific domain only, as seen in multiple studies utilizing the PTGI with different ethnic groups. Also, counselors should be aware of their own expectations and biases, as they may believe that PTG is more likely to occur among individuals in some cultural groups than others because cultural differences in the importance of spirituality, individuality, and collectivism may impact the one's perceptions of growth or willingness to disclose traumatic experiences with others. It may be especially important for trainee therapists to be aware of these biases, as they may impact their clients' openness to discussing their experiences of trauma, as well as the therapists' openness to engage in helping the client to facilitate the PTG process in psychotherapy. There is little research that explores recommendations to trainee therapists, which is described next.

Recommendations for Trainee Therapists

The efficacy of therapy conducted by trainee therapists and paraprofessionals has been studied in the literature. Christenson and Jacobson (1994) noted that often paraprofessionals or professionals with limited experience perform as well or better than professionally trained psychotherapists in providing psychotherapy. Research also suggests that the experience of the therapist has little effect on the outcome of therapy (Driscoll et al., 2003) and that therapy outcomes do not differ as a result of the education or years of experience of the therapist (Dawes, 1994). Therapy outcome success is often attributed to common factors in therapy including empathy, warmth, and genuineness (Driscoll et al., 2003).

Although graduate student trainee therapists are exposed to multiple theoretical orientations and to some degree of integrative training (Boswell, Castonguay, & Pincus, 2009), Boswell et al. suggested that trainee therapists do not have the benefit of making judgments

about using theoretical orientation and interventions using accumulated clinical experience, such as arriving at the integration of orientations through trainee therapists' own discovery of limitations throughout their clinical work. However, research examining cognitive therapy (CT) training programs indicated that theoretical and didactic components can be combined with clinical supervision to improve trainees' knowledge and skills, in line with the development of evidence-based practice (Milne, Baker, Blackburn, James, & Reichelt, 1999).

Trainee therapists are usually evaluated in areas of training such as competency and personal growth (Deacon & Piercy, 2000). While quantitative measures have advantages in evaluation process such as tracking student performance, Deacon and Piercy suggested that training programs using qualitative methods of evaluation whereby feedback is obtained about the trainees' experience would provide a rich sense of what is working and not working from the students' perspective. As such, qualitative studies have focused on trainee therapists' learning and change experiences, such as how psychotherapists might learn through their work with clients, the forms and contexts in which this learning may arise, and how the learning might affect the trainees (Turner, Gibson, Bennetts, & Hunt, 2008). For example, themes that arose regarding trainees' learning experiences included struggles with confidence, learning about themselves, learning about therapy, and learning about the rewards and challenges of being a therapist (Turner et al., 2008).

Turner and colleagues (2008) suggested that since learning from client work may involve learning from mistakes and/or some experimentation such as with session length, without the support of good supervision there is potential for the client to suffer as a consequence of a trainee's learning processes. To promote ethical practice, Turner and colleagues asserted that critical evaluation of all learning is particularly important, and that trainees should be encouraged

to work with their supervisors to analyze critically any learning they have experienced with a focus on the client's best interests.

However, as it pertains to the study of trainee therapists and PTG, research using quantitative or qualitative methods, specifically examining or recommending how trainee therapists may promote growth in psychotherapy is nonexistent. Therefore, research examining the use of recommendations promoting PTG, especially as it may relate to trainee therapists, would be a valuable contribution to the literature.

Summary and Purpose of the Study

Several definitions of trauma have been described, as well as how culture may impact one's experience of trauma and how a positive psychological approach addresses positive outcomes in addition to maladaptive functioning following traumatic events. More specifically, while survivors of trauma often experience distressing emotions in response to a traumatic event, some may experience posttraumatic growth (PTG), or positive changes resulting from their struggle with trauma. How individuals discuss their traumatic experiences with others may impact their experiences of PTG. Because therapists may be able to help their clients to facilitate growth following trauma or highly stressful events, the process of growth was described.

Terminology used in the literature to describe growth following trauma and adversity, closely related constructs, as well as several proposed models of PTG were summarized and critiqued.

Methods for assessing PTG were also discussed and critiqued, including qualitative, quantitative methods, validity issues, and cultural implications. The most widely used assessment measure for PTG, the Posttraumatic Growth Inventory (PTGI), was also described, including the multicultural populations for which it has been used.

Lastly, various recommendations and interventions for facilitating PTG in psychotherapy were discussed. Because this research focuses on trainee therapist's use of Calhoun and Tedeschi's (1999) counseling strategies for facilitating PTG in psychotherapy, the literature review concluded with a discussion examining paraprofessionals and trainee therapists, including their efficacy in implementing therapy interventions.

The purpose of this study was to explore the extent to which trainee therapists utilized a strength-based approach to facilitate PTG by following recommended counseling strategies that may be similar to those they have learned in their training. More specifically, it explored the extent to which trainee therapists used Calhoun and Tedeschi's (1999) strategies for facilitating the PTG of clients who have previously experienced trauma. The study examined if and how the trainee therapist(s) labeled clients' statements about trauma as struggles and opportunities for growth. The study aimed to bridge a gap related to how therapists may promote the process of growth following trauma in psychotherapy, in addition to enhancing the applicability of the recommended counseling strategies in Calhoun and Tedeschi's clinician's guide.

Research Question

The primary research question explored by this research study was: In what ways do training therapists respond to client expressions of trauma according to some of Calhoun and Tedeschi's (1999) recommendations for how to facilitate posttraumatic growth in psychotherapy sessions?

Chapter 2. Method

The purpose of this chapter is to present a summary of the methods used during the course of the study. First, the chapter provides a description of the research design strategy and approach, participants, researchers, instrumentation, study procedures, and ethical considerations. Next, the data analysis approach used and steps that were taken are discussed.

Research Design

Qualitative research is appropriate when understanding the context or setting in which participants confront dilemmas or concerns, when investigating topics for which there is a dearth of research, and when trying to explain existing theories that do not adequately explain the question being explored (Creswell, 2007; Morrow, 2007). It is used when answering questions of “How” or “What,” instead of “Why” (Morrow, 2007). Furthermore, qualitative research may be particularly useful in clinical and counseling psychology research because it is congruent with models and methods used in clinical practice (Morrow, 2007).

More specifically, qualitative methods can be applied using a clinical research strategy to investigate the therapist-client relationship (Mertens, 2009). Clinical research design was developed to adapt to the peculiarities of trying to understand a problem within a clinical context (Mertens, 2009). This method of inquiry can also be used to better understand the multiple forces that influence the effectiveness of different types of therapy (Mertens, 2009). Thus, the present study will use a clinical research design as the method of inquiry to explore the extent to which trainee therapists use Calhoun and Tedeschi’s (1999) recommended counseling strategies for facilitating PTG in psychotherapy sessions.

A treatment process approach was used to guide the present clinical research study. This approach is used to name, describe, classify, and count behavior of the therapist and client

(Stiles, Honos-Webb, & Knobloch, 1999). Stiles et al. suggested that the treatment process can be described using a variety of categories or measures, including (a) size of the scoring unit, such as single words, phrases, topic episodes, timed intervals of various durations, whole sessions, phases of treatment, whole treatment, and series of treatments, (b) perspective, or view point of the therapist/client, (c) data format and access strategy, such as transcripts, session notes, and audio/videotapes, (d) measure format, such as coding used to classify data into nominal categories, rating, or Q-sort, (e) level of inference, distinguishing the *classical strategy* in which only observable behavior is coded, from the *pragmatic strategy* in which the coders or raters make inferences about the speaker's thoughts, feelings, intentions, or motivations based on the observed behavior, (f) theoretical orientation, ranging from specific orientations to broader applicability, (g) treatment modality, such as individual adult, child, family, group therapy, (h) target person, including the therapist, client, dyad, family, or group as the focus of measurement, (i) communication channel, such as verbal, paralinguistic, or kinesic, and (j) dimension of verbal coding measures, including *content categories* which describe semantic meaning (i.e., "fear"), *speech act categories* which concern the manner in which the speech was conveyed (i.e., reflections, interpretations, questions, and self-disclosures), and *paralinguistic measures* which describe behaviors that are not verbal but accompany speech, such as hesitations and tonal qualities. The choice of measure used in the treatment process approach depends on the specific hypothesis, question, or topic being investigated (Stiles et al., 1999).

After applying some of these measures or categories describing the treatment process approach, the researcher can report measures directly through case studies or intensive analyses of brief segments; but more often measures are aggregated across some stretch of treatment or summarizing unit (Stiles et al., 1999). For example, the frequency or percentage of a category in

each session may be described, or the average of a rating across a whole treatment (Stiles et al., 1999). A description of how the treatment process approach was applied in this study, including descriptions of the categories or measures and how they were applied and reported is provided in the following sections of this chapter.

Participants

Client-participants. Five psychotherapy cases were selected from an archival database of video-recorded psychotherapy sessions from Southern California university-based community counseling centers. Random purposeful sampling was used to select the participants based on general guidelines for qualitative research (Creswell, 1998; Patton, 1990). All participants were required to be at least 18 years of age at the time of intake, English-speaking, and have given written consent for written records and videotaping to be included in the archival research database. The therapists of the participants also must have given written consent to have their session tapes placed in the research database.

Only cases with sufficient data were included in this study. Sufficient data was defined as participants who had at least one videotaped recording available of a session early in treatment (within the first half number of sessions) as well as later in treatment (within the second half number of sessions), in which a traumatic event or experience was discussed. The participants were required to have participated in psychotherapy for at least two months, or eight sessions, for the researcher to be able to examine growth over time. Calhoun and Tedeschi (1999) suggested that although a time frame for when an individual experiences PTG is unclear, it may take several months for an individual to begin to perceive one's struggle with trauma as a potentially growthful experience. Thus, two video-recorded psychotherapy sessions were used to enable coders to analyze data both during an earlier session and a later session of therapy, and the

videotaped sessions and written measures must have included discussion of trauma that was directly experienced by the participant (see Instrumentation section). The exception to the inclusion criteria was with Participant 5, in which only one video-recorded session was obtained. For Participant 5 only two tapes of the 15 sessions contained trauma discussions. Because these two tapes were back-to-back from the latter half of the course of therapy, an early session could not be obtained.

There were two exclusion criteria. Therapists of the participants were required to be individuals with whom the researchers did not have a close personal relationship independent of engaging in professionally sanctioned activities required by the clinical psychology doctoral program. This criterion was created for the purposes of further protecting confidentiality of both the therapists and the participants, as well as reducing the potential of researcher bias in the coding process. Also, persons who were seeking therapy in a modality other than individual therapy (e.g., couples, child/adolescent, family therapy) were not included in the sample. There were no specifications for the participant related to gender, socioeconomic status, race/ethnicity or religiosity.

Thus, to examine whether and to what extent trainee therapists used Calhoun and Tedeschi's (1999) recommended counseling strategies to promote PTG with clients who have experienced trauma, the participants whose psychotherapy sessions were analyzed in this study presented with histories of broadly-defined trauma that included both threats to *physical* integrity and *psychological* integrity, including (a) exposure to a negative event, and (b) the distress or psychological reaction to the exposure (Briere & Scott, 2006; Hall & Sales, 2007). A description of each of the 5 client-participants is described next, after a table including demographic information (see Table 1).

Table 1

Client-Participant Demographic Information

Participant	Age	Gender	Ethnicity	Trauma Description	Diagnoses
1	34	M	Caucasian	Suicide/Robbery	PTSD, Partner Relational Problem
2	21	F	Latina	Childhood Physical/Emotional Abuse	MDD, BPD
3	31	M	Turkish	Family Acculturation Stress	MDD, GAD
4	47	F	European	Stroke/Blindness	No diagnosis
5	29	M	Korean-American	Sudden Death of Friend	Social Phobia

Note. Definitions of abbreviations are as follows PTSD = Posttraumatic Stress Disorder; MDD = Major Depressive Disorder; BPD = Borderline Personality Disorder; GAD = Generalized Anxiety Disorder.

Participant 1. Participant 1 was a single 33-year-old Caucasian male of European descent who identified as Christian. A high school graduate with no children, Participant 1 described his occupation as a cinematographer but was unemployed at the time of intake. Participant 1 experienced two accidental deaths of his brothers at an early age, the recent suicide of another brother, and a recent home invasion robbery in which he and his girlfriend were tied up and held at gunpoint. When he presented to treatment he exhibited related symptoms of trauma including relational problems, somatization, tension reducing behaviors such as a history of polysubstance abuse in an effort to self-regulate, and a diagnosis of PTSD.

Specifically, Participant 1's symptoms at intake included panic symptoms (racing heart, sweating, shortness of breath, lightheadedness), hypervigilance, avoidance of thoughts/feelings/places that were reminders of the traumatic events, difficulty concentrating, sleep difficulties, a loss of interest in activities, social withdrawal, and loss of motivation. He

had also been experiencing significant interpersonal conflict with his live-in ex-girlfriend due to his belief that he was responsible for her “becoming bipolar” after the home invasion.

Participant 1 presented with somatic complaints reportedly due to stress since the home invasion robbery, including back and shoulder pain. Participant 1’s substance use included smoking marijuana 2 to 3 times per week reportedly as a means to cope with his stress related to the robbery.

According to the Termination Summary, Participant 1’s clinic therapist reported using Cognitive-Behaviorally-informed interventions to help the client address guilt and other issues in his relationship with his ex-girlfriend, as well as his PTSD symptoms. Treatment also included a mindfulness component to help Participant 1 with anxiety management. There were a total of 15 sessions and treatment was terminated prematurely as result of the Participant 1 not scheduling follow-up therapy sessions.

Because Participant 1 was diagnosed with PTSD by his clinic therapist as documented in his Intake Evaluation and Treatment Summary, his discussions of trauma were classified by the researcher as encompassing *DSM-IV-TR specific* trauma. The two psychotherapy sessions selected and transcribed for analysis include (a) *early* session number 6, dated 3/30/2009, and (b) *later* session number 12, dated 6/09/2009.

Participant 2. Participant 2 was a married 21-year-old Hispanic female with a high school equivalent education, no children, and an occupation as a house cleaner. Participant 2 described herself as an undocumented immigrant from El Salvador who was adopted by one of her aunts at the age of 2 because her biological mother no longer wanted to take care of her. Participant 2 experienced physical, emotional, and sexual abuse as a child, with trauma symptomology including an inability to trust others (relational problems), suicidality 5 weeks

prior to starting therapy, cognitive distortions, difficulty self-regulating, low self esteem, and diagnoses of Major Depressive Disorder (MDD) and Borderline Personality Disorder (BPD).

Participant 2 also reported interpersonal conflict with her husband, anger, impulsivity, and the presence of few interpersonal relationships. Participant 2 reported a history of experiencing severe physical and verbal abuse by her biological mother, another aunt, and grandmother between the ages of 11 and 17, including being beaten with cords as well as her mother attempting several times to kill her by trying to stab her with a knife. Participant 2 also reported two incidents of sexual abuse at the age of 11 by a cousin.

According to the Termination Summary, the clinic therapist reported using Dialectical-Behaviorally-informed interventions to help Participant 2 build skills in emotional regulation, distress tolerance, and communication, and reduce suicidal ideation. Treatment last for 31 sessions and was terminated prematurely as result of Participant 2's refusal to attend the recommended two sessions per week as required by the therapist to meet the clinic's standard of care. According to the Termination Summary, Participant 2 was not in a state of crisis at the time of termination and was referred to another counseling center to receive services.

Because Participant 2 was diagnosed with a rule out of PTSD by her clinic therapist as documented in her Intake Evaluation and Treatment Summary, discussions of trauma were classified by the researchers as meeting criteria for *DSM-IV-TR specific* trauma. As treatment progressed, Participant 2 was assigned an additional diagnosis of BPD. The two psychotherapy sessions selected and transcribed for analysis include (a) *early* session number 6, dated 11/20/2007, and (b) *later* session (number not specified by clinic therapist), dated 4/03/2008.

Participant 3. Participant 3 was a single 31-year-old Turkish, Orthodox Christian male with no children who had been receiving a college education at the time of treatment. Participant

3 immigrated to the United States 10 years prior to attend an occupational school. Participant 3 experienced childhood anxiety, his father's death from liver cancer 6 years prior, and past and current difficulties with issues of acculturation and family conflict associated with his immigration to in United States. His difficulty with acculturating, worries and rumination, as well as feelings of guilt and sadness about not being present for his father's death due to living the United States, contributed to his diagnoses of MDD and Generalized Anxiety Disorder (GAD).

Participant 3's symptoms at the time of intake included diminished interested in pleasurable activities, difficulty sleeping, fatigue, guilt, poor concentration, and an inability to stop worrying about multiple problems. According to the clinic therapist, his anxiety and depressive symptoms were a result of feelings of guilt related to not being in close proximity to his mother and sister, Participant 3 also reported frustrations around issues of acculturation and establishing a close social community of individuals with similar values to his own as well as experiences of perfectionism related to significant pressure to succeed academically.

According to the Termination Summary, the clinic therapist reported using cognitive-behaviorally-informed interventions to help Participant 3 address his negative conclusions about himself, beliefs about how he and others should act, and perfectionism stemming from beliefs that he is inadequate. The focus of treatment was predominantly on Participant 3's conflict about whether to stay in the United States or return to Turkey. Treatment lasted 9 sessions and was terminated prematurely due to Participant 3 canceling numerous sessions and being described as resistant to committing to weekly therapy.

Participant 3's type of trauma was classified by the researcher as a *stressful life event (SLE)* trauma; he did not meet criteria for the DSM-IV-TR's diagnosis of PTSD as documented

in the clinic therapist's Intake Evaluation. The two psychotherapy sessions selected and transcribed for analysis include (a) *early* session number 4, dated 11/09/2007, and (b) *later* session number 6, dated 2/01/2008.

Participant 4. Participant 4 was a 47-year-old religious (unspecified denomination) British female with no children and an Associates degree. Participant 4 experienced childhood abandonment by her father and emotional neglect by her aunt and uncle, and was adopted at the age of 9. These experiences in addition to her medical conditions including a recent stroke, which was causing her to go blind, were complicated by her presentation of relational problems, cognitive distortions, tension reducing behaviors including compulsive scratching, and low self-esteem. While she was not formally diagnosed with a DSM-IV-TR diagnosis, her presentation suggests a history and symptomology characteristic of trauma.

Participant 4 initially presented to therapy to address symptoms of frequent crying and skin scratching, both of which began 6 weeks prior to the intake and after her stroke. Because Participant 4 also had medical complications due to diabetes, including neuropathy in both of her legs and numbness on the right side of her body, she experienced fear of losing her limbs. Her loss of sight and new need for dependence on others in order to negotiate daily activities activated feelings from her childhood related to abandonment by her father and emotional neglect by her aunt and uncle.

The course of treatment for this client-participant was unclear, as there was no Termination Summary. However, based on other chart documentation sources (e.g., appointment log, dates and numbers of DVD-recorded sessions) it was estimated that treatment lasted approximately 12 sessions.

Participant 4's type of trauma was classified by the researchers as a *stressful life event (SLE)* trauma because she did not meet criteria for the DSM-IV's diagnosis of PTSD as documented in the clinic therapist's Intake Evaluation. The two psychotherapy sessions selected and transcribed for analysis include (a) *early* session number 6, dated 1/23/2007, and (b) *later* session number 12, dated 5/01/2007.

Participant 5. Participant 5 was a single 29-year-old Korean male with no children. He identified himself as a college graduate working in the computer industry. Participant 5 reported a history of possible drug and alcohol abuse, emotional abuse, discrimination (e.g., insults, hate crimes), acculturation issues related to his immigration from South Korea to the United States, and anxiety related to his difficulty in understanding the unexpected death of his close friend two months prior to his intake session. Participant 5 presented with negative thinking, worry, low self-esteem, and was diagnosed with Social Phobia. Participant 5 also reported a history of anxiety since childhood, as well as recent worries about dating and social situations (initiated by the death of his friend).

According to the Termination Summary, the clinic therapist reported using cognitive-behaviorally-informed interventions to enhance Participant 5's understanding of the connection between his thoughts, feelings, and behaviors, educate him about social anxiety, teach relaxation strategies, help increase assertiveness, and help reduce negative-oriented thinking. Treatment lasted 15 sessions. According to the clinic therapist, therapy was terminated prematurely due to issues with rapport, miscommunication, experiencing the client as slightly argumentative and confrontational, and expressing that he hates women (therapist was female).

Because Participant 5's experience of his friend's death is classified in the DSM-IV-TR as an example of a traumatic event included in the criteria for PTSD, the researcher categorized

Participant 5's trauma as *DSM-IV-TR specific*. The psychotherapy session selected and transcribed for trauma discussion analysis is session 10 (date not specified by clinic therapist), which is categorized as a *later* session due to it taking place in the last half of the client's total of 15 sessions.

Researcher-participants. The researchers in the current study consisted of a team of three clinical psychology doctoral students who coded the data (Coders 1, 2, and 3) and one auditor, who was the clinical psychologist that supervised the research. Several researchers were used to provide a variety of opinions and perspectives, which helped to circumvent the biases of any one person, and capture the complexity of the data (Hill et al., 1997). Coders 1, 2, and 3 independently examined the data prior to meeting together as a group to discuss each other's codes and come to a consensus. To avoid potential group bias in the coding process or consensual observer drift, which refers to coders modifying their recordings to agree with those of another coder with whom they previously had the opportunity to compare ratings (Harris & Lahey, 1982), each coder preserved a copy of his or her initial independently-derived codes, in addition to the codes discussed upon group consensus. During the group discussions when the coders were required to make judgment calls, as in cases of inter-rater disagreement, the rationale for each judgment was documented in an audit trail using an electronically-shared document so that the auditor could obtain an understanding of the coder judgment process (Orwin, 1994). The coders then submitted their final code agreement using an electronically-shared document to the auditor, who served as an additional check of the team's judgments (Hill et al., 1997). As part of the larger research project, each of the coders and the auditor provided a description of themselves in order to identify potential areas of bias.

Coder 1, the primary researcher and author of this dissertation, is a 29-year-old female of Ukrainian and Native American descent who is a doctoral student in clinical psychology. She generally conceptualizes clients and conducts psychotherapy from a cognitive behavioral perspective. Through her training and experience in this theoretical orientation, Coder 1 believes that one's interpretation of a situation often expressed in automatic thoughts, influences one's subsequent emotions, behaviors, and physiological responses. Consistent with the cognitive model, she believes that enduring improvement results from realistically evaluating and modifying biased thinking in one's automatic thoughts, rules, assumptions, attitudes, and underlying dysfunctional core beliefs about oneself, the world, and others. Coder 1 is also a proponent of eastern philosophy principles such as Mindfulness practices that have been integrated into cognitive-behavioral-oriented psychotherapeutic treatments such as dialectical behavior therapy. She is supportive of evidence-based treatments and has a general interest in assessing and treating traumatic stress disorders in children and adults. Coder 1 believes that, while not experienced by everyone, many individuals can benefit from psychotherapy as a means to cognitively reevaluate their schemas that have been challenged by traumatic stress, and subsequently experience PTG in the process as they struggle to understand and create new meaning in their lives.

Coder 2 is a 31-year old, first-generation Armenian-American female doctoral student in clinical psychology whose parents immigrated to the United States over 30 years ago. Coder 2 generally conceptualizes clients and conducts psychotherapy from a psychodynamic perspective. Through her training and experience in this theoretical orientation, she has come to believe in the importance of significant human relationships and the effects they have on individuals' view of themselves and of the world. For individuals who have experienced a

traumatic event, the importance of this interpersonal connection and relationship is heightened, and the extent to which significant others in the individuals' lives support their need for autonomy and personal competence determines the degree of growth that can be experienced by the individual. The therapeutic relationship is an essential medium of autonomy support for clients who have experienced trauma. Therefore, Coder 2 believes that, independent of ethnic cultural background, all clients would benefit from therapy that would support the universal need for autonomy, facilitating the human tendency towards posttraumatic growth following an adverse event.

Coder 3 is a 31-year-old, Caucasian Welsh/German male doctoral student in clinical psychology. His family has lived in the United States for over two hundred years and he has been brought up in the upper middle class. Coder 3 generally conceptualizes clients and conducts psychotherapy from a psychodynamic perspective, incorporating elements from cognitive and strength-based models of treatment. In his training and experience, he has observed that the information provided by psychological theory and research is not always easily absorbed and integrated by students during their training. He feels that an unfortunate consequence of the increasing body of literature is that many training models (as seen, for example, in the disparity between traditional deficit-based models and growth-based models of positive psychology) seem to be in conflict with one another. He believes that as clinical theory moves away from a dichotomous definition of trauma, training therapists will have increased difficulty in applying theory in practice. For these reasons, Coder 3 feels it is important to examine how student trainee therapists reconcile these conflicts and actually conduct therapeutic work with clients who have experienced a variety of negative events.

The auditor of the study, the dissertation chairperson, is a 43-year-old, European-American, progressive, Christian, married woman of middle to high socioeconomic status. As an associate professor of psychology with degrees in clinical psychology and law, she teaches, mentors and engages in independent and collaborative research with students, including coders 1-3, and colleagues. The auditor believes in the integration of diverse fields of inquiry and of research and practice. Accordingly, she generally conceptualizes clients using multiple theoretical perspectives (including behavioral, cognitive-behavioral, dialectical behavior therapy, family systems, stages of change and other strength-based and positive psychology approaches) and is supportive of evidence-based treatments. Regarding this study, she hopes that a client who has experienced trauma and discusses it in therapy would share some growth-related expressions.

Instrumentation

Selection criteria. Several instruments were used to determine how client-participants were selected for the study. An archival database provided clinic forms to determine whether or not a prospective client-participant had experienced a trauma, as well as videotaped psychotherapy sessions to determine if a trauma was discussed. For prospective client-participants, their clinic forms were used to initially identify experiences of trauma. If an experience of trauma was indicated on the forms, the researcher-participants viewed videotaped psychotherapy sessions in order to corroborate the written information. How the researcher located within psychotherapy videotapes the experience of trauma, discussions of trauma, and therapists' use of Calhoun and Tedeschi's (1999) strategies is discussed in this section.

Step 1: Archival database. The written data and psychotherapy sessions being examined in this study were obtained from an archival research database at the Pepperdine University

Graduate School of Education and Psychology community counseling clinics. This database includes the therapists' written material about their clients, measures completed by all clients at the clinics at the intake session and at five session intervals, and videotapes of psychotherapy sessions. These measures are used to determine the needs and strengths of clients, and to monitor their progress and satisfaction.

Step 2: Determining experience of trauma. In this study, *trauma* was defined as both threats to *physical* integrity and *psychological* integrity, including (a) exposure to a negative event, and (b) the distress or psychological reaction to the exposure (Briere & Scott, 2006; Hall & Sales, 2007). *Trauma* also encompassed complex psychological trauma resulting from exposure to severe stressors that (a) were repetitive and chronic, (b) involved harm or abandonment by caregivers or other responsible adults, and (c) occurred at developmentally vulnerable times in the victim's life, such as early childhood or adolescence (Ford & Courtois, 2009).

To determine if a potential participant had experienced a trauma in his or her life, multiple instruments from the archival database were examined. The researcher-participants first examined prospective client-participants' Client Information Adult Form to determine if a trauma had been indicated.

Client Information Adult Form. To capture the more conservative definition of trauma as an event that threatens one's physical integrity (Briere & Scott, 2006), it was required that at least 3 of the 5 participants must have experienced a traumatic event that was consistent with DSM-IV-TR criteria. In the Family Data Section of the Client Information Adult Form (see Appendix A), the client must have indicated "yes this happened" in the Self column under the question "Which of the following have family members including yourself struggled with?" for

at least one of the following: Death and Loss, Sexual Abuse, Physical Abuse, Rape/Sexual Assault, Debilitating Illness Injury, or Disability. These categories meet the DSM-IV-TR criteria for what constitutes a traumatic event. The remaining participants chosen for the study were required to have identified any of the remaining categories specified in the Self column as indicators of trauma or Stressful Life Events (SLE), as these events may be subsumed under the more broad definition of trauma that includes events that may threaten one's psychological integrity, such as Emotional Abuse and Separation/Divorce, for example. This way, both types of traumatic events (SLE and DSM-IV-TR) could be represented in the sample when looking at patterns of therapist responding to discussions of both life-threatening trauma and psychologically threatening trauma. If the client indicated "yes this happened" in the Family or Other column, information from the other following instruments were used to corroborate this information to determine if it impacted the client's presenting experience trauma(s).

If a trauma was indicated on this form, the Intake Evaluation Summary, the Telephone Intake Summary and Treatment Summary were used to identify additional information, if any, related to clients' experience of trauma. More specifically, the researchers searched for any discussion of the trauma in the Intake Evaluation Summary (see Appendix B), where the therapist could indicate that the client discussed the trauma in at least one of the following sections: Presenting Problems (section 2), History of Presenting Problems (section 3), and/or Psychosocial History (section 4). Additional information related to the trauma was also found using the Treatment Summary form (see Appendix C), or on the Telephone Intake form in the Reason for Referral section (see Appendix D).

Step 3: Identifying a discussion of trauma. Because the term *trauma* refers not only to negative *events* that produce distress but also to the *distress* itself (Briere & Scott, 2006), the

trauma-related data indicated on the forms previously discussed were corroborated with information pertaining to the client's *perception* of distress as indicated in the client discussions of trauma in the videotapes of the participant's psychotherapy sessions. Based upon definitions of disclosure in the literature (Chelune, 1979; Cozby, 1973; Jourard, 1971; Omarzu, 2000; Pennebaker, Zech, & Rimé, 2001), *discussion of trauma* was identified in participant videotapes as verbalizations consisting of (a) descriptions of the traumatic event, (b) evaluative content such as thoughts, beliefs, and attitudes about the traumatic event, and (c) affective content such as one's feelings and emotions about the traumatic event. For example in the following discussion,

I saw her one time, um, put an iron right to his chest and when I saw these things happening, I just I grew really afraid of her. And so when we would argue I knew what she was capable of so, I would stay clear of any like physical, anything physical with her. I would try to talk my way out of it.

the client described the event, as well as her thoughts and feelings about it. Additional examples of these verbalizations are contained in the coding manual (see Appendix E). To identify when a discussion of trauma occurred, videotapes of the participants' psychotherapy sessions were viewed by the researchers and searched for any discussions of the trauma that were indicated on the Client Information Adult Form, Intake Evaluation Summary, Treatment Summary Form, and Telephone Intake Form.

Coding counseling strategies. The extent to which trainee therapists used Calhoun and Tedeschi's (1999) recommended counseling strategies in response to client discussions of trauma were explored, specifically "Focus on listening without necessarily trying to solve" (p. 61), "Label growth when it is there" (p. 64), "Events that are too horrible" (p. 66), and "Choosing the right words" (p. 66). The recommendation "Notice growth as the client approaches it" (p. 63) was not examined because Tedeschi and Calhoun conceptualized it as an internal process of the therapist rather than as concrete verbalizations that can be objectively coded by the researchers.

The following operational definitions were used to create a coding system (see coding manual in Appendix E) to identify, record in an electronically-shared data tracking sheet, and analyze therapist responses that were consistent with Calhoun and Tedeschi's recommendations for facilitating PTG in psychotherapy.

Focus on listening without trying to solve. The recommendation *Focus on listening without trying to solve* was operationally defined using Rautalinko and Lisper's (2004) categories of reflective listening, which they derived from theory and prior research (e.g., Hill, 1992; Lindh & Lisper, 1990; Rogers, 1961) and used in their content analysis of reflective listening in counseling (see Rautalinko, Lisper, & Ekehammar, 2007). The researcher broke down Calhoun and Tedeschi's first recommendation into a series of *focus on listening* codes, and *without trying to solve* codes.

Based on Rautalinko and Lisper's (2004) categories of reflective listening, the researcher's *Focus on listening* initial codes included (a) minimal encouraging (Code FL1), which consist of short utterances that listeners do automatically such as saying "Uh-um" or "Yes," or nodding, (b) direct encouraging (Code FL2), which is when the listener explicitly encourages the other to continue talking, such as saying "Go on," "Continue, or "Tell me more," (c) reflecting or rephrasing or restating the other's factual (Code FL3a), emotional (Code FL3b), or nonverbal (Code FL3d), utterance in one's own words, and (d) questioning, which consists of questioning on fact or questioning on emotion, in which both types may be classified as open-questions (Code FL4aF-O or Code FL4bE-O) or closed-ended questions (Code FL4cF-C or Code FL4dE-C). Open questions are defined as those that request clarification or exploration without purposely limiting the nature of the response, whereas closed questions elicit specific and limited

information from the client, usually requesting a one- or two-word answer such as “yes” or “no” as confirmation of the therapist’s previous statement (Hill, 1992).

New categories FL4amb-O and FL4amb-C were created during the coding process to capture therapist responses that appeared ambiguous in their presentation as questioning on *thoughts* versus *feelings*. Additionally, the category of reflecting includes (a) reflecting fact (Code FL3a), which describes rephrasing that focuses on content, (b) reflecting emotion (Code FL3b), which focuses on rephrasing feelings, and (c) nonverbal referent (Code FL3d), which involves reflecting aspects of nonverbal behavior (Hill, 1992). Also, the coders developed an additional code (FL3c) to capture therapist responses reflecting or rephrasing ambiguous thoughts and/or feelings. This code was developed because the coders found it helpful to capture therapist responses that were reflective in nature but that did not exclusively fit into the categories of *thoughts* or *feelings*.

Next, the *Without trying to solve* component of *Focus on listening without trying to solve* was operationally defined as the absence of advice giving (Code FLTS-A). Advice giving was a non-reflective listening category that emerged from Rautalinko, Lisper, and Ekehammar’s (2007) content analysis of psychology students who role-played counseling conversations with confederates. Gordon (1970) also emphasized that reflective listening involves the receiver not sending a message of his own, such as an evaluation, opinion, or advice. Therapist behavior such as providing opinions and giving advice connotes behavior incongruent with *Focusing on listening*. Rautalinko et al.’s other non-reflective listening category that emerged from their content analysis included interpretation, which occurs when the therapist presents a new meaning, reason, or explanation for behaviors, feelings, or thoughts other than what the client has overtly stated (Hill, 1992). Although interpretations may connote behavior incongruent with

Focusing on listening, the therapists' use of an interpretation may be used to signify a different Calhoun and Tedeschi (1999) counseling strategy (i.e., *Choosing the right words*) and therefore was not coded in this recommendation category.

In addition to FLTS-A (advice giving/opinion), the coders developed codes FLTS-I to indicate a therapist response that provided a treatment-focused intervention as a means to problem solve, and FLTS-amb to capture a therapist response that appeared ambiguous in its presentation as personal opinion/advice, a treatment recommendation as a means to solve, or both. Thus codes FLTS-I (intervention-focused problem solving) and FLTS-amb (ambiguous advice/opinion/treatment-focused solving) were developed in addition to FLTS-A (advice giving/opinion) during the initial coding process when the 3 coders observed these multiple forms of therapist problem-solving responses thought to be valuable to capture for analysis of the *Focus on Listening without Trying to Solve* recommendation.

Labeling growth when it is there. The recommendation *Labeling growth when it is there* was operationally defined as (a) the therapist verbalized positive changes that the client identified as already present (Code LGa) (*positive changes* are defined as a transformation or transition from one state, condition, or phase to another, tending towards progress or improvement) and (b) the therapist reframed the way the client viewed certain events (Code LGb). *Reframe* is defined as to look at, present, or think of thoughts, beliefs, ideas, and relationships in a new or different way.

Events that are too horrible. The recommendation of the therapist addressing *Events that are too horrible*, or the therapist's willingness to think about the client's experience in terms of PTG, was operationally defined as when the therapist (a) shared with the client that some individuals stated they have changed in some positive ways as they coped with their trauma

(Code EHa), and (b) elicited whether the client thought that this was possible for him/her given what he/she has gone through (Code EHb).

Choosing the right words. *Choosing the right words* was operationally defined with two codes. First, the therapist reinforced the positive interpretations of growth or positive changes coming from the struggle with trauma when the client made them (Code CWa). *Reinforces* was defined as the therapist emphasizes, stresses, or supports when the client explains a positive meaning, significance, or change resulting from his or her struggle with trauma. Second, the therapist chose to label or identify client statements reflecting PTG with words that reflected the individual's *struggle* to survive and come to terms with the event, as opposed to the event itself (Code CWb). In this code (a) *labeling* was defined as the therapist describing or recognizing client statements reflecting his or her struggle to survive, (b) words synonymous with the word *struggle* include *strive, carry on, fight, wrestle, grapple, battle, contend, go up against, or put up a fight*, and (c) *coming to terms with the event* was defined as starting to accept and deal with a difficult situation.

Procedures

Sampling procedure. Each participant completed a written consent form to include his or her written and video materials in the archival research database. This study used purposive sampling based on general guidelines for qualitative and observational research to create a pool of potential participants who meet the inclusion criteria (Creswell, 1998; Mertens, 2005) to target the specific phenomenon being studied.

Step 1. A complete list of identification numbers for de-identified clients who agreed to be included in the research database were obtained.

Step 2. English-speaking adults over the age of 18 who partook in individual therapy were selected for the researchers to view their clinic measures for evidence of trauma.

Step 3. The sample was narrowed to clients who had reported experiencing trauma, and more specifically the type of trauma (i.e., *DSM-IV-IV trauma* or *SLE*).

Step 4. The sample was narrowed to those who had at least 8 sessions video-taped.

Step 5. The researchers reviewed the videos of the remaining clients and narrowed down the sample to clients who discussed trauma in two or more videotaped therapy sessions.

Step 6. Of the remaining potential client-participants, five were selected based on specific client characteristics and demographics of age, gender, race/ethnicity, religious affiliation, socioeconomic status, and presenting issues. These variables were considered to ensure that a representative sample of the counseling centers' population was obtained. The researchers obtained information from the clinic director to obtain estimates regarding the characteristics of the community counseling clinic population.

Step 7. With the exception of participant 5, two tapes per client were selected for coding; one *early* psychotherapy session (sessions 1-5) and one *later* session (mid-treatment through termination). Videotapes were viewed from latest to earliest in the course of therapy. Thus, in the event that more than one later session included a trauma discussion, the later of the two sessions was selected. Of the *early* sessions available, the earliest session post-intake was chosen.

Transcription. The research coders recorded the occurrence and duration of each client discussion of trauma and therapist responses located in the videotaped psychotherapy sessions.

A total of seven Master's level psychology graduate students were hired as research assistants

and trained to transcribe verbatim whole videotaped therapy sessions that included discussions of trauma (refer to the coding manual in Appendix F for transcription procedures).

Coding. Three doctoral level psychology graduate students served as the coders for this study (Coders 1, 2, and 3). The three coders were trained to understand the essential concepts, terms, and issues that were relevant to the study including how to accurately identify and code occurrences of client discussions of trauma and therapist responses that are consistent with recommendations for facilitating PTG. Before coding the videotapes, coders practiced coding until they reached 66% agreement on practice cases. Coding took place after training had been completed, and after the research assistants transcribed sessions in which there was a discussion of trauma.

Team members examined and coded the data independently, and then came together to present and discuss their ideas. The coders documented their judgment process as to how they came to “agree” or “disagree” to reach their consensus of codes for each client-participant in an electronically-shared document to present to the auditor.

The team members presented and discussed their suggested codes until they reached a 66% consensus of the best representation of the data. The researchers recorded what level of agreement was in place after independent coding prior to the group discussion. Post discussion of inter-rater reliability data was also completed. This process is described next.

Inter-rater Reliability

Inter-rater reliability among the three coders prior to and after group discussion was calculated using Fleiss’ kappa coefficient (K; Fleiss, 1971). Table 2 outlines the K scores obtained for each code as well as the average for each code across participants. This coefficient was computed in order to test whether the agreement among coders exceeded what would be

expected if all coders made their ratings completely randomly (Gwet, 2010). Fleiss' kappa is used with nominal-scale ratings to assess the reliability of agreement between a fixed numbers of raters. The advantage over Cohen's kappa is that it can be used when assessing the agreement between more than two raters, which was the case for the current study (Fleiss, Cohen, & Everitt, 1969).

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

Both pre-group and post-group discussions yielded *almost perfect* agreement ($0.81 < K < 1.00$) for all codes, which was higher than expected by chance. The pre-group discussion averaged observed agreement of .863-.999, and the post-discussion averaged observed agreement of .994-1.00. This may suggest that the coders were well trained in using each other's coding systems, in addition to potential coder drift.

Table 2

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

	Fleiss' Kappa	Observed Agreement	Expected Agreement		Fleiss' Kappa	Observed Agreement	Expected Agreement
FL1				FL4amb-C			
1a	0.852	0.939	0.586	1a	N/A	N/A	N/A
1b	0.935	0.972	0.567	1b	0.710	0.992	0.972
2a	0.869	0.948	0.601	2a	N/A	N/A	N/A
2b	0.919	0.974	0.682	2b	N/A	N/A	N/A
3a	0.915	0.966	0.605	3a	-0.003	0.993	0.993

(continued)

	Fliess' Kappa	Observed Agreement	Expected Agreement		Fliess' Kappa	Observed Agreement	Expected Agreement
3b	0.958	0.986	0.676	3b	N/A	N/A	N/A
4a	0.892	0.950	0.535	4a	-0.003	0.995	0.995
4b	0.884	0.961	0.665	4b	N/A	N/A	N/A
5	0.978	0.991	0.575	5	-0.005	0.991	0.991
Average	0.911	0.965	0.610	Average	0.175	0.993	0.993
FL2				FL4amb-O			
1a	N/A	N/A	N/A	1a	N/A	N/A	N/A
1b	N/A	N/A	N/A	1b	N/A	N/A	N/A
2a	0.748	0.996	0.985	2a	N/A	N/A	N/A
2b	0.497	0.994	0.987	2b	N/A	N/A	N/A
3a	N/A	N/A	N/A	3a	N/A	N/A	N/A
3b	N/A	N/A	N/A	3b	N/A	N/A	N/A
4a	N/A	N/A	N/A	4a	-0.005	0.990	0.990
4b	N/A	N/A	N/A	4b	N/A	N/A	N/A
5	-0.005	0.991	0.991	5	-0.005	0.991	0.991
Average	0.413	0.994	0.988	Average	-0.005	0.991	0.991
FL3a				FLTS-A			
1a	0.795	0.973	0.867	1a	N/A	N/A	N/A
1b	0.403	0.952	0.919	1b	1	1	0.976
2a	0.830	0.940	0.649	2a	N/A	N/A	N/A
2b	0.709	0.891	0.625	2b	N/A	N/A	N/A
3a	0.827	0.966	0.805	3a	N/A	N/A	N/A
3b	0.891	0.970	0.723	3b	-0.001	0.997	0.997
4a	0.842	0.985	0.905	4a	1	1	0.985
4b	0.849	0.970	0.795	4b	1	1	0.911
5	0.563	0.918	0.812	5	N/A	N/A	N/A
Average	0.745	0.952	0.789	Average	0.750	0.999	0.967
FL3b				FLTS-I			
1a	-0.003	0.993	0.993	1a	N/A	N/A	N/A
1b	0.420	0.984	0.972	1b	0.907	0.996	0.957
2a	0.784	0.970	0.862	2a	1	1	0.978
2b	0.519	0.942	0.880	2b	1	1	0.908
3a	0.631	0.974	0.928	3a	1	1	0.993
3b	0.519	0.942	0.880	3b	1	1	0.984
4a	0.769	0.975	0.891	4a	0.761	0.985	0.937
4b	0.757	0.977	0.904	4b	1	1	0.911
5	0.697	0.954	0.849	5	N/A	N/A	N/A
Average	0.565	0.863	0.907	Average	0.953	0.997	0.953

(continued)

	Fliess' Kappa	Observed Agreement	Expected Agreement		Fliess' Kappa	Observed Agreement	Expected Agreement
FL3c				FLTS-amb			
1a	-0.003	0.993	0.993	1a	N/A	N/A	N/A
1b	0.498	0.996	0.992	1b	N/A	N/A	N/A
2a	1	1	0.989	2a	N/A	N/A	N/A
2b	0.327	0.987	0.981	2b	-0.006	0.987	0.987
3a	-0.004	0.993	0.993	3a	N/A	N/A	N/A
3b	0.194	0.989	0.986	3b	N/A	N/A	N/A
4a	-0.003	0.995	0.995	4a	N/A	N/A	N/A
4b	-0.012	0.977	0.977	4b	N/A	N/A	N/A
5	0.315	0.963	0.947	5	N/A	N/A	N/A
Average	0.257	0.988	0.984	Average	-0.006	0.987	0.987
FL3d	N/A	N/A	N/A	LGa			
1a	N/A	N/A	N/A	1a	N/A	N/A	N/A
1b	N/A	N/A	N/A	1b	-0.008	0.984	0.984
2a	N/A	N/A	N/A	2a	-0.004	0.993	0.993
2b	N/A	N/A	N/A	2b	0.340	0.955	0.932
3a	N/A	N/A	N/A	3a	N/A	N/A	N/A
3b	N/A	N/A	N/A	3b	0.578	0.981	0.954
4a	N/A	N/A	N/A	4a	N/A	N/A	N/A
4b	N/A	N/A	N/A	4b	N/A	N/A	N/A
5	N/A	N/A	N/A	5	N/A	N/A	N/A
Average	N/A	N/A	N/A	Average	0.227	0.978	0.966
FL4aF-O				LGb			
1a	0.497	0.993	0.986	1a	N/A	N/A	N/A
1b	0.774	0.992	0.965	1b	-0.006	0.988	0.988
2a	0.830	0.974	0.846	2a	0.275	0.966	0.878
2b	0.824	0.962	0.781	2b	0.679	0.974	0.920
3a	0.871	0.993	0.994	3a	N/A	N/A	N/A
3b	0.664	0.995	0.984	3b	0.730	0.986	0.949
4a	0.775	0.965	0.857	4a	N/A	N/A	N/A
4b	0.876	0.977	0.813	4b	0.746	0.992	0.969
5	0.652	0.972	0.920	5	0.795	0.991	0.955
Average	0.751	0.980	0.905	Average	0.537	0.983	-0.943
FL4cF-C				EHa			
1a	0.820	0.966	0.811	1a	N/A	N/A	N/A
1b	0.828	0.972	0.842	1b	N/A	N/A	N/A
2a	0.807	0.914	0.557	2a	N/A	N/A	N/A
2b	0.690	0.904	0.689	2b	N/A	N/A	N/A
3a	0.847	0.981	0.874	3a	N/A	N/A	N/A
3b	0.629	0.973	0.926	3b	N/A	N/A	N/A

(continued)

	Fliess' Kappa	Observed Agreement	Expected Agreement		Fliess' Kappa	Observed Agreement	Expected Agreement
4a	0.775	0.965	0.857	4a	N/A	N/A	N/A
4b	0.957	0.984	0.643	4b	N/A	N/A	N/A
5	0.741	0.982	0.930	5	-0.005	0.991	0.991
Average	0.788	0.960	0.792	Average	-0.005	0.991	0.991
FL4bE-O				EHb			
1a	0.594	0.986	0.967	1a	N/A	N/A	N/A
1b	0.855	0.987	0.926	1b	N/A	N/A	N/A
2a	0.830	0.993	0.956	2a	N/A	N/A	N/A
2b	0.827	0.987	0.926	2b	N/A	N/A	N/A
3a	0.835	0.990	0.942	3a	N/A	N/A	N/A
3b	0.835	0.991	0.943	3b	N/A	N/A	N/A
4a	0.755	0.965	0.857	4a	N/A	N/A	N/A
4b	1	1	0.995	4b	N/A	N/A	N/A
5	0.495	0.991	0.982	5	N/A	N/A	N/A
Average	0.781	0.998	0.944	Average	N/A	N/A	N/A
FL4dE-C				CWA			
1a	0.793	0.986	0.934	1a	N/A	N/A	N/A
1b	0.663	0.992	0.976	1b	N/A	N/A	N/A
2a	0.836	0.989	0.932	2a	N/A	N/A	N/A
2b	0.827	0.987	0.926	2b	-0.003	0.994	0.994
3a	0.908	0.998	0.974	3a	N/A	N/A	N/A
3b	N/A	N/A	N/A	3b	N/A	N/A	N/A
4a	0.328	0.990	0.985	4a	N/A	N/A	N/A
4b	0.659	0.984	0.955	4b	N/A	N/A	N/A
5	N/A	N/A	N/A	5	N/A	N/A	N/A
Average	0.716	0.989	0.955	Average	-0.003	0.994	0.994
NOS				CWb			
1a	1	1	0.980	1a	N/A	N/A	N/A
1b	0.498	0.996	0.992	1b	N/A	N/A	N/A
2a	0.780	0.974	0.881	2a	-0.006	0.989	0.989
2b	0.609	0.942	0.853	2b	N/A	N/A	N/A
3a	0.866	0.990	0.928	3a	N/A	N/A	N/A
3b	0.912	0.992	0.906	3b	N/A	N/A	N/A
4a	0.718	0.995	0.840	4a	N/A	N/A	N/A
4b	-0.008	0.984	0.985	4b	N/A	N/A	N/A
5	0.490	0.927	0.857	5	N/A	N/A	N/A
Average	0.652	0.978	0.914	Average	-0.006	0.989	0.989

Note. Coefficients marked with an asterisk (*) indicate average inter-rater reliability values across those sessions that included the code.

Table 3

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

	Fliess' Kappa	Observed Agreement	Expected Agreement		Fliess' Kappa	Observed Agreement	Expected Agreement
FL1				FL4amb-C			
1a	1	1	0.663	1a	N/A	N/A	N/A
1b	1	1	0.565	1b	1	1	0.965
2a	1	1	0.596	2a	1	1	0.989
2b	1	1	0.656	2b	N/A	N/A	N/A
3a	0.994	0.998	0.624	3a	1	1	0.979
3b	0.991	0.997	0.685	3b	N/A	N/A	N/A
4a	0.989	0.995	0.542	4a	1	1	0.970
4b	0.979	0.992	0.639	4b	N/A	N/A	N/A
5	1	1	0.579	5	1	1	0.973
Average	0.995	0.998	0.617	Average	1	1	0.975
FL2				FL4amb-O			
1a	0.748	0.996	0.985	1a	N/A	N/A	N/A
1b	N/A	N/A	N/A	1b	N/A	N/A	N/A
2a	1	1	0.989	2a	N/A	N/A	N/A
2b	N/A	N/A	N/A	2b	N/A	N/A	N/A
3a	N/A	N/A	N/A	3a	N/A	N/A	N/A
3b	N/A	N/A	N/A	3b	N/A	N/A	N/A
4a	N/A	N/A	N/A	4a	1	1	0.928
4b	N/A	N/A	N/A	4b	N/A	N/A	N/A
5	N/A	N/A	N/A	5	1	1	0.973
Average	0.874	0.998	0.987	Average	1	1	0.951
FL3a				FLTS-A			
1a	0.962	0.993	0.822	1a	N/A	N/A	N/A
1b	1	1	0.930	1b	1	1	0.976
2a	0.990	0.996	0.622	2a	N/A	N/A	N/A
2b	0.984	0.994	0.595	2b	N/A	N/A	N/A
3a	0.977	0.995	0.790	3a	N/A	N/A	N/A
3b	0.981	0.995	0.707	3b	1	1	0.992
4a	1	1	0.900	4a	1	1	0.985
4b	1	1	0.813	4b	1	1	0.911
5	1	1	0.849	5	N/A	N/A	N/A
Average	0.988	0.997	0.781	Average	1	1	0.996

(continued)

	Fliess' Kappa	Observed Agreement	Expected Agreement		Fliess' Kappa	Observed Agreement	Expected Agreement
FL3b				FLTS-I			
1a	-0.003	0.993	0.993	1a	N/A	N/A	N/A
1b	1	1	0.988	1b	1	1	0.942
2a	0.975	0.975	0.996	2a	1	1	0.978
2b	1	1	0.908	2b	1	1	0.908
3a	1	1	0.924	3a	1	1	0.993
3b	1	1	0.968	3b	1	1	0.984
4a	1	1	0.887	4a	1	1	0.914
4b	1	1	0.955	4b	1	1	0.911
5	1	1	0.872	5	N/A	N/A	N/A
Average	0.886	0.996	0.943	Average	1	1	0.947
FL3c				FLTS-amb			
1a	-0.003	0.993	0.993	1a	N/A	N/A	N/A
1b	1	1	0.976	1b	N/A	N/A	N/A
2a	1	1	0.989	2a	N/A	N/A	N/A
2b	1	1	0.944	2b	1	1	0.962
3a	1	1	0.965	3a	N/A	N/A	N/A
3b	1	1	0.936	3b	N/A	N/A	N/A
4a	1	1	0.985	4a	N/A	N/A	N/A
4b	1	1	0.933	4b	N/A	N/A	N/A
5	1	1	0.872	5	N/A	N/A	N/A
Average	0.889	0.999	0.995	Average	1	1	0.962
FL3d				LGa			
1a	N/A	N/A	N/A	1a	N/A	N/A	N/A
1b	N/A	N/A	N/A	1b	1	1	0.988
2a	N/A	N/A	N/A	2a	0.873	0.996	0.971
2b	N/A	N/A	N/A	2b	1	1	0.874
3a	N/A	N/A	N/A	3a	N/A	N/A	N/A
3b	N/A	N/A	N/A	3b	1	1	0.936
4a	N/A	N/A	N/A	4a	N/A	N/A	N/A
4b	N/A	N/A	N/A	4b	N/A	N/A	N/A
5	N/A	N/A	N/A	5	N/A	N/A	N/A
Average	N/A	N/A	N/A	Average	0.968	0.999	0.942
FL4aF-O				LGb			
1a	1	1	0.980	1a	N/A	N/A	N/A
1b	1	1	0.965	1b	0.873	0.996	0.968
2a	1	1	0.828	2a	1	1	0.838
2b	0.948	0.987	0.753	2b	1	1	0.944
3a	0.967	0.998	0.928	3a	N/A	N/A	N/A
3b	1	1	0.976	3b	1	1	0.936
4a	1	1	0.848	4a	N/A	N/A	N/A

(continued)

	Fliess' Kappa	Observed Agreement	Expected Agreement		Fliess' Kappa	Observed Agreement	Expected Agreement
4b	1	1	0.831	4b	1	1	0.955
5	1	1	0.947	5	1	1	0.973
Average	0.991	0.998	0.895	Average	0.979	0.999	0.936
FL4cF-C				EHa			
1a	0.898	0.980	0.801	1a	N/A	N/A	N/A
1b	1	1	0.826	1b	N/A	N/A	N/A
2a	1	1	0.547	2a	N/A	N/A	N/A
2b	1	1	0.635	2b	N/A	N/A	N/A
3a	0.983	0.998	0.858	3a	N/A	N/A	N/A
3b	0.969	0.997	0.911	3b	N/A	N/A	N/A
4a	0.972	0.990	0.642	4a	N/A	N/A	N/A
4b	1	1	0.631	4b	N/A	N/A	N/A
5	1	1	0.947	5	1	1	0.973
Average	0.980	0.996	0.755	Average	1	1	0.973
FL4bE-O				EHb			
1a	1	1	0.960	1a	N/A	N/A	N/A
1b	1	1	0.976	1b	N/A	N/A	N/A
2a	0.907	0.996	0.960	2a	N/A	N/A	N/A
2b	1	1	0.926	2b	N/A	N/A	N/A
3a	0.923	0.995	0.937	3a	N/A	N/A	N/A
3b	1	1	0.939	3b	N/A	N/A	N/A
4a	1	1	0.970	4a	N/A	N/A	N/A
4b	1	1	0.955	4b	N/A	N/A	N/A
5	N/A	N/A	N/A	5	N/A	N/A	N/A
Average	0.979	0.999	0.953	Average	N/A	N/A	N/A
FL4dE-C				CWA			
1a	1	1	0.922	1a	N/A	N/A	N/A
1b	1	1	0.988	1b	N/A	N/A	N/A
2a	N/A	N/A	N/A	2a	N/A	N/A	N/A
2b	1	1	0.926	2b	-0.003	0.994	0.994
3a	1	1	0.972	3a	N/A	N/A	N/A
3b	N/A	N/A	N/A	3b	N/A	N/A	N/A
4a	1	1	0.970	4a	N/A	N/A	N/A
4b	1	1	0.955	4b	N/A	N/A	N/A
5	N/A	N/A	N/A	5	N/A	N/A	N/A
Average	1	1	0.956	Average	-0.003	0.994	0.994

(continued)

	Fliess' Kappa	Observed Agreement	Expected Agreement		Fliess' Kappa	Observed Agreement	Expected Agreement
NOS				CWb			
1a	1	1	0.980	1a	N/A	N/A	N/A
1b	1	1	0.856	1b	N/A	N/A	N/A
2a	1	1	0.857	2a	-0.006	0.989	0.989
2b	0.971	0.994	0.776	2b	N/A	N/A	N/A
3a	0.902	0.993	0.926	3a	N/A	N/A	N/A
3b	0.951	0.995	0.889	3b	N/A	N/A	N/A
4a	0.983	0.995	0.711	4a	N/A	N/A	N/A
4b	1	1	0.727	4b	N/A	N/A	N/A
5	1	1	0.764	5	N/A	N/A	N/A
Average	0.979	0.997	0.832	Average	-0.006	0.989	0.989

Note. Coefficients marked with an asterisk (*) indicate average inter-rater reliability values across those sessions that included the code.

Auditor. Once the team completed the work of coming to a consensus about the coding of the data, they gave the case to the auditor, who served as a check for the team (Hill et al., 1997). Having an auditor who was very involved in the study but outside the consensual process provided a different perspective to keep the team on track (Hill et al., 1997). The auditor performed several steps, which are described next.

Step 1. The auditor read through all of the raw material (i.e. transcripts), to determine whether all of the data reflective of the codes had been abstracted by the coders (Hill et al., 1997). The auditor thought about how she would approach the coding and match her ideas with those of the team (Hill et al., 1997).

Step 2. The auditor questioned any discrepancies that arose with the team's judgment, and provided suggestions for changes in the team members' coding (Hill et al., 1997), which was recorded in the electronically-shared audit trail. Feedback provided by the auditor encouraged the primary team members to think carefully about the abstracting and come up with the best possible construction of the data (Hill et al., 1997).

Step 3. The auditor provided her comments to the team to discuss together and reach a consensus. This step enabled the auditor to see how the team had responded to each comment, as well as provided more feedback if the auditor felt strongly that the team was not including relevant information (Hill et al., 1997).

Human Subjects/Ethical Considerations

All participants consented to have their records included in the research database prior to the intake interview at the community clinic (see Appendix F). All therapists in the study also consented to allow their therapy tapes and client records to be part of the research database (see Appendix G). Limits of confidentiality were reviewed during the intake procedure. To preserve participant confidentiality, all identifying information was removed from the clients' written documents. A research number was assigned to each research participant in order to de-identify their information.

In addition, each researcher/coder and transcriber completed an IRB certification course and Health Insurance Portability & Accountability Act of 1996 (HIPAA) course to increase understanding and adherence to ethical subject research. All researchers signed a confidentiality statement indicating they would keep all sensitive information confidential (see Appendix H). Internal Review Board (IRB) approval to conduct the following study was obtained on September 2, 2010 (see Appendix I).

Data Analysis Approach

A naturalistic qualitative content analysis approach was used to analyze the data. As outlined by Creswell (1998) and Smith (2004), content analysis allows researchers to study individuals in depth and to reduce a large amount of information into smaller meaningful units of representation. As one of the numerous research methods used to analyze text data (Hsieh &

Shannon, 2005), qualitative content analysis focuses on the characteristics of language as communication with attention to the content or contextual meaning of the text (Budd, Thorp, & Donohew, 1967; Lindkvist, 1981; McTavish & Pirro, 1990; Tesch, 1990). This method of analysis can be applied to archival or live data, provides a rich, complex perspective of the construct of interest (i.e. recommendations for facilitating PTG in psychotherapy), and can be implemented unobtrusively (Gottschalk, 1974; Schilling, 2006). Coding and content analysis of taped psychotherapy sessions and examination of written materials from an archival research database thus have the advantage of being non-reactive and unobtrusive (Smith, 2004).

Content analysis has increased in application and popularity as a method of qualitative analysis for health researchers (Nandy & Sarvela, 1997). A number of researchers have argued that methods such as qualitative and quantitative content analyses of written and verbal material should be used in the study of psychotherapy (Creswell, 1998; Flores & Obasi, 2003; Hubble, Duncan, & Miller, 1999; Lopez & Snyder, 2003; Schilling, 2006; Viney, 1983). For example, Viney (1983) noted that content analysis is pan theoretical in that it is a method of analyzing language expression above and beyond theoretical assumptions of the various schools of psychotherapeutic orientation (Viney, 1983).

More specifically, a directed approach to content analysis uses a deductive use of theory to validate or conceptually extend a theoretical framework or theory (Hsieh & Shannon, 2005). Existing theory or research can provide predictions about the variables of interest or about the relationships among variables (Hsieh & Shannon, 2005). Thus a direct approach uses existing theory or research to help focus the research question and can help determine the initial coding scheme or relationships between codes (Hsieh & Shannon, 2005). For the purpose of this study which was to more closely examine how trainee therapists may facilitate PTG in psychotherapy,

Calhoun and Tedeschi's (1999) recommendations served as an initial framework to (a) help identify key concepts or variables as initial coding categories, and (b) determine operational definitions for each recommendation category. In addition, Rautalinko and Lisper's (2004) categories of reflective listening, as well as Rautalinko et al.'s (2007) non-reflective listening categories were used to help operationalize Calhoun and Tedeschi's recommended counseling strategies. Calhoun and Tedeschi's theory was used to guide the discussion of findings, to offer a contradictory view of the phenomenon of PTG or to further refine, extend, and enrich current recommendations for facilitating PTG in psychotherapy.

Data Analysis Steps

For auditability, the researchers provided an audit trail, or a sufficiently clear and full account of the research process so that the reader could judge the dependability of the qualitative study (Lincoln & Guba, 1985). A clear description of the research path included research design and data collection decisions and the steps taken to manage, analyze and report the data.

Lincoln and Guba (1985) cite Halpern's (1983) categories of information that should be reported in developing the audit trail, including (a) raw data, (b) data reduction and analysis products including quantitative summaries and theoretical notes, (c) data reconstruction and synthesis notes such as the structure of categories (themes, definitions, and relationships) and a report including connections to existing literatures, (d) process notes including methodological notes (procedures, designs, strategies, rationales) and trustworthiness notes, (e) instrument development information, and (f) materials related to intentions and dispositions such as personal notes and expectations. The first four categories of information (a, b, c, d) were tracked; notes were recorded in a coding journal and analysis products and a report including connections to existing literatures was presented. The next category, instrument development, does not apply to

this study. The last category was recorded using the technique of bracketing, which is described next.

Bracketing is a means by which researchers (a) attempt to not allow their assumptions to shape the data collection process and impose their own understanding and constructions on the data, (b) demonstrate the validity of the data collection and analytic processes, and (c) facilitate the process of data collection. A reflexive journal was used to write down issues that would enhance the researcher's reflexivity and ability to bracket (Ahern, 1999). Before beginning the procedures of the study, the researcher recorded several issues recommended by Ahern (1999) to enhance the reflexive bracketing process. Issues included (a) identifying interests that as a researcher, one might take for granted in undertaking this research, including assumptions associated with gender, race, and where one belongs in the power hierarchy in relation to the research project, (b) clarifying one's personal value system and acknowledge areas in which one knows he/she is subjective, (c) describing possible areas of potential role conflict, (d) identifying gatekeepers' interests and consider the extent to which they are disposed favorably toward the project, and (e) recognizing feelings that could indicate a lack of neutrality. Ahern also suggests identifying if anything is new or surprising in the data analysis. The researchers in the study (Coders 1, 2, and 3, as well as the auditor), kept his or her own reflexivity journal.

To analyze the data, several steps took place.

Step 1. The coders examined the participant's videotaped psychotherapy sessions and note any discussions of trauma.

Step 2. The research assistants transcribed sessions that contained client discussions of trauma as well as the therapist's responses to these discussions of trauma for the coders to

review. The coders discussed and agreed upon the start and stop points of the trauma discussions before beginning initial coding.

Step 3. To facilitate the bracketing process, the coders and auditor recorded their thoughts and biases in their reflexivity journals and discussed them as a group prior to beginning coding the data. The primary researcher's observed personal biases that impacted coding decisions throughout the data analysis are discussed here.

Before coding, the researcher discussed with the team that she would be attuned to looking for therapist and client responses indicative of positive changes following trauma. She also expressed that during the coding process, she was critical of therapists who missed opportunities to reflect positive changes voiced by the clients. The researcher exhibited bias toward choosing therapist response codes consistent with facilitating PTG, especially codes reflective of Recommendations #2 *Labeling Growth When It is There*. For example, it was not uncommon for the researcher to code therapist responses as reframing what the client stated as reflecting positive changes, when in fact they were viewed as neutral changes by the other two coders. The researcher also more easily identified in the psychotherapy transcripts examples of discussions in which the therapists missed opportunities to use responses consistent with facilitating PTG according to the coded recommendations, more so than what the other two coders expressed. Although the author of this study expressed these biases, she feels that they minimally impacted the coding process in a negative way due to her continuous self-monitoring using the reflexive journal and audit trail, as well as discussing these biases with the other coders.

Step 4. The coders used the following predetermined codes located in the coding manual as units of analysis to identify therapist responses consistent with Calhoun and Tedeschi's (1999)

recommendations: FL1, FL2, FL3a, FL3b, FL3c, FL4aF-O, FL4bE-O, FL4cF-C, FL4dE-C, FLTS, LGa, LGb, EHa, EHb, CWa, and CWb (as operationally defined above and located in the coding manual). The following codes were developed later during the coding process to capture more specific therapist responses: FL3d, FL4amb-C, FL4amb-O and FLTS was broken down further into 3 codes: FLTS-A, FLTS-I, and FLTS-amb. Because the original FLTS code captured a range of problem-solving scenarios, three more specific codes were created to better capture the essence of different problem-solving responses. Other codes were created to capture ambiguous therapist responses such as FL3c for difficulty in differentiating the therapist reflecting a thought or a feeling. Code FL4amb-C was also created to capture the therapist's ambiguous response of questioning what could be interpreted as a thought or a feeling. Lastly, when coding the therapist's response of factual content versus emotional content, content that implied cognitive processes such as "thinking" or "worry" were coded as factual information. Data that could not be coded as Calhoun and Tedeschi's recommendations within the trauma discussion was identified using the code NOS (*Not Otherwise Specified*) and was later analyzed by the author to determine if they represented a new category (Hsieh & Shannon, 2005).

After the coders independently coded the transcripts, they came together as a group via conference call to reach a consensus regarding final codes for the data before submitting their findings using electronically shared transcript documents to the auditor of the study. Talk turns in which codes were reached with 2/3 (66%) agreement among the coders were noted in the audit trail as well as in the transcripts to ensure the accuracy of inter-rater agreement calculations. The coders also submitted questions to the auditor regarding her input on coding decisions using the electronically shared audit trail document.

The coders discussed how their potential biases and thoughts may have impacted their coding and discussion process. For example, as previously noted, the author shared how she may have been more attuned to interpreting therapist responses as congruent with strength-based responses in their coding systems, as well as criticisms of therapist responses that appeared to neglect opportunities for growth.

Step 5. Once this portion of the data analysis was completed and reviewed by the auditor for each of the nine transcript documents, the team of coders participated in conference calls to discuss the auditor's feedback before deciding on final codes that were in question. All final data was then entered and organized into an electronically-shared data sheet. The data table includes session ID and the frequency of therapist response codes including those that did not fit in the predetermined categories for each of the nine sessions.

Step 6. All data was submitted to ReCal ("Reliability Calculator"; Freelon, 2010), a web-based program that computes inter-rater reliability coefficients for nominal, ordinal, interval, or ratio-level data and is compatible with Excel, SPSS, and any other database, spreadsheet, or statistical application that can export comma-separated (CSV), tab-separated (TSV), or semicolon-delimited data files. ReCal3 was used to obtain results valid for nominal data coded by three or more coders. Numerical values for Fleiss' kappa, observed agreement, and average pairwise percent agreement were obtained and reported to represent both pre-group discussion and post-group discussion inter-rater agreement (see Table 2).

Step 7. The frequency or percentage of therapist responses that corresponded with categories consistent with Calhoun and Tedeschi's (1999) recommended counseling strategies were examined to elucidate how training therapists may facilitate PTG in psychotherapy sessions. The data was evaluated for patterns based on variables such as specific

recommendation used and data that did not describe a predetermined coded recommendation. Client tapes were also examined across each of the five clients' set of sessions to determine if growth occurred over time (with the exception of Participant 5).

Chapter 3. Results

This chapter presents the results of the content analysis of nine therapy sessions across five participants designed to elucidate how training therapists may facilitate PTG in psychotherapy sessions. As described in the method section, the following predetermined codes and codes developed during the coding process were used as units of analysis to identify therapist responses consistent with Calhoun and Tedeschi's (1999) recommended counseling strategies: Recommendation #1 *Focus on Listening Without Trying to Solve*; FL1, FL2, FL3a, FL3b, FL3c, FL3d, FL4aF-O, FL4cF-C, FL4bE-O, FL4dE-C, FL4amb-C, FL4amb-O, FLTS-A, FLTS-I, FLTS-amb; Recommendation #2 *Labeling Growth When it is There*; LGa, LGb; Recommendation #3 *Events That are Too Horrible*; EHa, EHb; Recommendation #4 *Choosing the Right Words*; CWa, CWb; and NOS (as operationally defined above and located in the coding manual). Results consisting of frequency and percentage of therapist coded responses across participants as well as across individual sessions are presented with examples of therapist responses taken from psychotherapy session transcripts to qualitatively illustrate how therapists responded to clients' discussions' of trauma.

Across all 9 sessions of the 5 participants in the study, a total of 1,350 transcribed therapist talk turns occurred in the context of trauma discussion and were coded by the researchers. Table 4 illustrates the frequency of codes assigned to therapist responses during client discussion of trauma for *early* and *later* sessions of each of the 5 participants (with the exception of participant 5 in which only a *later* session was analyzed). Table 5 provides percentages and totals of codes used in addition to frequency of responses.

Table 4

Frequency of Codes Across Participant Sessions

Recommendation Codes	Client 1		Client 2		Client 3		Client 4		Client 5
	1a	1b	2a	2b	3a	3b	4a	4b	5a
Total Talk Turns Per Session									
Total TTs: 1350	97	165	178	103	276	241	132	86	72
REC 1	Frequency of Codes Per Session								
FL1	81	113	53	21	213	184	47	20	50
FL2	0	0	1	1	0	0	0	0	1
FL3a	9	8	44	31	26	43	7	10	7
FL3b	0	1	14	4	11	4	7	2	5
FL3c	1	1	1	2	5	7	1	4	5
FL3d	0	0	0	0	0	0	0	0	0
FL4aF-O	0	3	18	14	10	3	10	9	2
FL4cF-C	10	14	59	25	21	12	23	21	2
FL4bE-O	2	2	1	4	7	5	2	2	0
FL4dE-C	4	1	6	4	3	0	2	2	0
FL4amb-C	0	3	1	0	3	0	2	0	1
FL4amb-O	1	0	0	0	0	0	4	0	1
FLTS-A	0	2	0	0	0	1	1	4	0
FLTS-I	0	5	2	5	1	2	7	1	0
FLTS-amb	0	0	0	3	0	0	0	0	0
REC 2									
LGa	0	1	3	7	0	8	0	0	0
LGb	0	2	16	3	0	7	0	2	1
REC 3									
EHa	0	0	0	0	0	0	0	0	1
EHb	0	0	0	0	0	0	0	0	0
REC 4									
CWa	0	0	0	1	0	0	0	0	0
CWb	0	0	1	0	0	0	0	0	0
NOS	1	12	15	12	13	14	21	15	10

Table 5

Percentage and Frequency of Therapist Response Codes

	Client 1		Client 2		Client 3		Client 4		Client 5
	1a	1b	2a	2b	3a	3b	4a	4b	5a
Talk Turns	97	165	178	103	276	241	132	86	72
FL1	81 83.5%	113 68.5%	53 29.8%	21 20.4%	213 77.2%	184 76.3%	47 35.6%	20 23.3%	50 69.4%
FL2	0	0	1 1%	1	0	0	0	0	1 1.4%
FL3a	9 9.3%	8 4.8%	44 24.7%	31 30.1%	26 9.4%	43 17.8%	7 5.3%	10 11.6%	7 9.7%
FL3b	0	1 0.6%	14 7.9%	4 3.9%	11 4%	4 1.7%	7 5.3%	2 11.6%	5 9.7%
FL3c	1 1%	1 0.6%	1 0.6%	2 1.9%	5 1.8%	7 2.9%	1 0.8%	4 4.7%	5 6.9%
FL3d	0	0	0	0	0	0	0	0	0
FL4aF-O	0	3 1.8%	18 10.1%	14 13.6%	10 3.6%	3 1.2%	10 7.6%	9 10.5%	2 2.8%
FL4cF-C	10 9.7%	14 8.5%	59 33.1%	25 24.3%	21 7.2%	12 5%	23 17.4%	21 24.4%	2 2.8%
FL4bE-O	2 2.1%	2 1.2%	1 0.6%	4 3.9%	7 2.5%	5 2.1%	2 1.5%	2 2.3%	0
FL4dE-C	4 4.1%	1 0.6%	6 3.4%	4 3.9%	3 1.1%	0	2 1.5%	2 2.3%	0
FL4amb-C	0	3 1.8%	1 0.6%	0	3 1.1%	0	2 1.5%	0	1 1.4%
FL4amb-O	1 1%	0	0	0	0	0	4 3%	0	1 1.4%
FLTS-A	0	2 1.2%	0	0	0	1 0.4%	1 0.8%	4 4.7%	0
FLTS-I	0	5 3%	2 1.1%	4 3.9%	1 0.4%	2 0.8%	6 4.5%	1 1.2%	0
FLTS-amb	0	0	0	3 2.9%	0	0	0	0	0
LGa	0	1 0.6%	3 1.7%	7 6.8%	0	8 3.3%	0	0	0
LGb	0	2 1.2%	16 9%	3 2.9%	0	7 2.9%	0	2 2.3%	1 1.4%
EHa	0	0	0	0	0	0	0	0	1 1.4%
EHb	0	0	0	0	0	0	0	0	0
CWa	0	0	0	1 1%	0	0	0	0	0
CWb	0	0	1 0.6%	0	0	0	0	0	0
NOS	1 1%	12 7.3%	15 8.4%	12 11.7%	13 4.7%	14 5.8%	21 15.9%	15 17.4%	10 13.9%

The mean (*M*) and standard deviation (*SD*) of therapist responses across each participant's *early* and *later* session (see Table 6) were also analyzed to determine if PTG may have occurred over time by comparing *early* and *later* session code frequencies. The *M* of all participants' *early* sessions as well as the *M* of all *later* sessions were also calculated to compare code frequencies across time (see Table 7). Data from these Tables 4 – 7 are presented in the Across and Within Participant sections that follow.

Table 6

Mean (M) and Standard Deviation (SD) of Codes Across Participant Sessions

Code	Client 1		Client 2		Client 3		Client 4		Client 5	Total	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	N/A	<i>M</i>	<i>SD</i>
FL1	97	22.6	37	22.6	198.5	20.5	33.5	19.1	50	86.9	69.7
FL2	0	1	0	0	0	0	0	0	1	0.33	0.5
FL3a	8.5	0.71	37.5	9.2	34.5	12	8.5	2.1	7	20.6	15.7
FL3b	0.50	0.71	9	7.1	7.5	5	4.5	3.5	5	6.4	4.6
FL3c	1	0	1.5	0.71	6	1.41	2.5	2.1	5	3	4.6
FL3d	0	0	0	0	0	0	0	0	0	0	0
FL4aF-O	1.5	2.1	16	2.8	6.5	5	9.5	0.71	2	6.8	6.1
FL4cF-C	12	2.8	42	24	16.5	6.4	22	1.4	2	20.8	16.1
FL4bE-O	2	0	2.5	2.1	6	1.4	2	0	0	2.8	2.5
FL4dE-C	2.5	2.1	5	1.4	0	0	2	0	0	2.4	2
FL4amb-C	1.5	2.1	0.5	0.71	0	0	1	1.4	1	1.1	1.3
FL4amb-O	0	0	0	0	0	0	2	2.8	1	0.67	1.32
FLTS-A	1	1.4	0	0	0.5	0.71	2.5	2.1	0	0.67	1.32
FLTS-I	2.5	3.5	3	1.4	1.5	0.71	3.5	3.54	0	2.3	2.2
FLTS-amb	0	0	1.5	2.1	0	0	0	0	0	0.33	1
LGa	0.5	0.71	5	2.8	4	5.7	0	0	0	2.1	3.2
LGb	1	1.4	9.5	9.2	3.5	5	0	0	1	3.4	5.2
EHa	0	0	0	0	0	0	0	0	1	0.11	0.33
EHb	0	0	0	0	0	0	0	0	0	0	0
CWa	0	0	1	0.71	0	0	0	0	0	0.11	0.33
CWb	0	0	1	0.71	0	0	0	0	0	0.11	0.33
NOS	6.5	7.8	13.5	2.1	13.5	0.71	18	4.2	10	12.6	5.3

Table 7

Mean (M) Codes Across Early and Late Sessions

Code	EARLY (M)	LATE (M)	LATE including Session#5 (M)
FL1	98.5	84.5	77.6
FL2	0.25	0.25	0.4
FL3a	21.75	23	19.8
FL3b	8	2.75	3.2
FL3c	2	3.5	3.8
FL3d	0	0	0
FL4aF-O	9.5	7.25	6.2
FL4cF-C	28.25	18	14.8
FL4bE-O	3	3.25	2.6
FL4dE-C	3.75	1.75	1.4
FL4amb-C	1.5	0.75	0.8
FL4amb-O	1.25	0	0.2
FLTS-A	0.25	1.75	1.4
FLTS-I	2.25	3	2.4
FLTS-Amb	0	0.75	0.6
LGa	0.75	4	3.2
LGb	4	3.5	2.8
EHa	0	0	0.2
EHb	0	0	0
CWa	0	0.25	0.2
CWb	0	0	0
NOS	12.5	13.25	12.6

Results Across Participants

Recommendation 1: Focus on listening without trying to solve. Across therapist-participants, *Focus on Listening* responses were the most frequently used by the therapists. Specifically, across the 9 participant sessions, *minimal encouraging* responses regularly occurred the most throughout the client sessions (FL1, $M = 86.9$, $SD = 69.7$). Some therapists responded to client discussions of trauma solely using a minimal encouraging response (e.g., “Uh hmm”), and others used them in conjunction with other phrases within the same talk-turn (e.g., nodding

proceeded by reflecting factual information). Across the 5 participants, therapists for Participants 1, 3, and 5 used minimal encouraging responses the most.

The next most common therapist responses were *questions about facts* or situational information regarding details about the traumatic or stressful life event, how the client coped with it, as well as about cognitive processes such as thoughts and worries related to the clients' decision-making processes. More specifically, therapists tended to ask more *closed-ended questions* (FL4cF-C, $M = 20.8$, $SD = 16.1$) than *open-ended questions* (FL4aF-O, $M = 6.78$, $SD = 6.06$) when gathering this information in their attempt to gain a better understanding of the client's situation including the details about the traumatic situations, how the client reacted in response to the traumatic situations, how others reacted, and the nature of romantic and familial relationships. Overall, therapists *reflected factual* content (FL3a, $M = 20.56$, $SD = 15.7$) as often as they asked closed-ended questions about it. Reflecting factual information often prompted further inquiry about factual information as well as emotions. Across the 5 participants, the therapists for Participants 2 and 3 related to the client's discussion using factual content the most (see next section for individual frequency data).

Although less frequently than responding to facts, therapists *reflected emotions* (FL3b, $M = 6.4$, $SD = 4.7$) regarding how their clients felt about the traumatic events they experienced as well as how they felt talking about them in session. Therapists more commonly reflected client's emotions than inquired about them. When they did *question about emotions*, they evidenced about the same amount of *open-ended questions* (FL4bE-O, $M = 2.8$, $SD = 2.5$) and *closed-ended questions* (FL4dE-C, $M = 2.4$, $SD = 2$). Some therapists focused questions and reflections of emotions related to how the client felt in session as he or she talked about his or her traumatic experience, whereas others inquired and reflected emotions related to hypothetical scenarios of

how the client would feel if he or she implemented particular coping strategies, such as writing, or made decisions affecting other individuals in their families. Specifically, across the 5 participants, the therapists for Participants 2 and 5 used responses that reflected the client's emotions the most.

Across participants, therapists used responses consistent with the *Trying to Solve* component of the *Focus on Listening Without Trying to Solve* recommendation less frequently than the other listening codes. When therapists did engage in problem-solving type of responses, they more often used *therapeutic interventions* (FLTS-I, $M = 2.33$, $SD = 2.18$) such as psychoeducation, mindfulness, and writing techniques rather than *advice-giving* based on personal opinion (FLTS-A, $M = 0.89$, $SD = 1.36$).

Lastly, across all 9 sessions, therapists rarely related to client discussions using ambiguous factual/emotion responses (FL3c, $M = 3$, $SD = 4.64$; FL4amb-C, $M = 1.11$, $SD = 1.2$; FL4amb-O, $M = 0.67$, $SD = 1.32$; FLTS-amb, $M = 0.33$, $SD = 1$). Also, *nonverbal referent* (FL3d) responses were not used to relate what the client was discussing in session with aspects of client non-verbal behaviors.

Recommendation 2: Label growth when it is there. Across participants, the next most commonly used recommendation regarding how to respond to clients' discussions of trauma were responses that labeled growth by either reframing or verbalizing positive changes the client had made. More therapists responded to their clients' discussions of trauma by *reframing* changes as positive (LGb, $M = 3.4$, $SD = 5.2$) than *verbalizing* them as positive when the client made reference to them (LGa $M = 2.1$, $SD = 3.2$). Across participants, 3 of the 5 therapists engaged in responses to discussions of trauma by verbalizing positive changes the client had made, all which occurred during their *later* sessions, with the exception of Participant 2, which

occurred in both the *early* and *later* sessions. All therapists across participants also engaged in responses that reframed their clients' changes in a positive way in their *later* sessions, again with the exception of the therapist for Participant 2, who engaged in this kind of responding in both the client's *early* and *later* sessions. The therapist for Participant 2 evidenced the highest amount of LGa and LGb responses (see next section for individual frequency data). The LGa and LGb responses typically occurred toward the end of the session, such as reframing clients' behavior as healthy rather than dysfunctional, how clients viewed others' behavior, and how clients were coping and maintaining self-care in better ways than earlier in treatment.

Recommendation 3: Events that are too horrible. Across all 9 sessions of the 5 participants, only one therapist used one response consistent with sharing with the client that other individuals have stated that they have changed in some positive ways as they coped with their trauma (EHa, $M = 0.1$, $SD = 0.3$). This occurred during Participant 5's discussion with his therapist about the sudden death of his friend, in which the therapist described that this kind of trauma has caused others to "wake up" in a sense and think about life differently.

Recommendation 4: Choosing the right words. Across all sessions, only 2 responses (CWa, $M = 0.1$, $SD = 0.3$; CWb, $M = 0.1$, $SD = 0.3$) in which the therapist *reinforced the positive interpretations of growth/changes coming from the client's struggle with trauma* and *identified client statements reflecting PTG with words that reflected the individual's struggle to survive* were used by the therapist treating Participant 2. The CWb response occurred during the discussion in the client's *early* session in which the client and therapist talked about the client behaving in self-defense with her violent family. The CWa response occurred in the client's *later* session during the discussion about the client becoming more receptive to change by

continuing to learn through therapy how to learn to trust people outside of therapy, such as new friends.

Early sessions versus later sessions. When comparing the means of therapist responses across participants in *early* sessions versus *later* sessions, therapist responses that occurred more frequently in the *later* sessions when comparing them with averages of *early* sessions include *reflecting fact* (FL3a), *reflecting ambiguous fact/feeling* (FL3c), *open-questioning on emotions* (FL4bE-O), all *opinion/advice* problem solving codes (FLTS I/A/amb), *verbalizing positive changes when the client makes them* (LGa), and *reinforcing the positive interpretations of growth or positive changes coming from the struggle with trauma when the client made them* (CWa). However, these averages were about the same, and only slightly larger than the *early* session data (see Table 7 for mean comparisons). These results indicate that to better assess for growth over time, it may be more valuable to compare individual *early* and *later* sessions rather than compare averages across participants in this study. There could also be other ways to assess for growth over time using qualitative and quantitative means, but this will be discussed later in the Discussion section. To accomplish this study's goal of examining therapist responses during individual participant sessions, as well as to explore potential growth over time, the frequency of codes used in each client session is discussed in more detail next. Examples from session transcripts are also provided to illustrate each therapist's responses to her client's discussions of trauma.

Participant 1

Early session. The researchers coded a total of 97 therapist talk turns in Participant 1's *early* session (session 6, date 3/30/09). Of these 97 talk turns, the researchers coded 81 responses (83.5%), the majority of the trauma discussion, consistent with *minimal encouraging*

(FL1), like nodding and “uh hum.” The therapist used this means of relating to the client throughout the session.

The next most frequent codes involved therapist responses concerning facts regarding the client’s relationship with his brother, his unanswered questions about why his brother committed suicide, the client’s own reasons for not committing suicide, and his personal decision to not move back to his hometown to help out his family in their time of grief. When the therapist *inquired about factual* details (FL4cF-C) about the nature of the client’s relationship with his brother, the client described the tension between the two of them, including his feeling that there was a “wall” between them, possibly due to his brother’s insecurity about being adopted and having a difficult past with drug use. Thus, the client initiated discussion of his emotions as the therapist asked him about situational facts. Ten responses (9.7%) were consistent with *closed-ended questioning on factual content* (FL4cF-C), which occurred more often than *open-ended questions* (FL4aF-C, 3 responses, 1.8%). For example, T93 responded to the client saying that he used to drink alcohol, smoke marijuana, and use pills as a way to escape his emotional pain, with, “Isn’t that kinda what you did when your other brother died?”

When the therapist *reflected factual* information (FL3a), the next most common response (nine responses; 9.3%), it prompted the client to talk more about his relationship with his now-deceased brother in detail, which in turn facilitated more questions by the therapist about his brother’s suicide as well as his own thoughts about suicide. Subsequently, when the client described that he had explored the idea of suicide quite a bit in the past and made a feature film about it, the therapist commented that the client stated before that he would not consider committing suicide after having made that movie. This reflection prompted the client to talk about reasons he would not kill himself, including his journey for having a higher purpose in life

and to make films to expose pain and help others to want to change their lives for the better as well. Rather than further exploring this journey for growth purposes, the therapist shifts back to the experience of the brother's death and asks the client if he envied that his sister cried once.

Later in the session, the therapist reflected the client's decision to not want to move back to his hometown to help his father, which prompted the client to describe that it would be nice to see his family more often but because he has been working on his film career and living on his own for the past 10 years, his father would not want him to leave to move back home. In the following example, as the client was talking about reasons to stay and reasons to go back home to assist his father, the therapist reflected that the experience of the client's brother's death was making the client's father become more involved with work again, "So it's kind of making your father become more hands on again" (T70).

Although infrequent, the next most common therapist responses involved *questions* about the client's *emotions*; more *closed-ended* (FL4dE-C, 4 responses, 4.1%) than *open-ended questions* (FL4bE-O, 2 responses, 2.1%) about the clients *emotions* were used. Near the beginning of the session the therapist inquired how it felt to the client to be back in his hometown for the funeral and to see old friends and family grieving the death of his adopted brother. The client described how sad he felt, especially seeing everyone else so upset. As the therapist inquired more, the client continued the discussion by trying to make sense of why his brother would have killed himself. The therapist further inquired if the whole experience of his brother's death felt unreal to him, if he felt different from when his other brother died, "Do you feel like this is different from when your other brother died" (T25)? The therapist wondered if he client had feelings of regret for not living closer, and if he felt like he could have stopped his brother from committing suicide, asking "Does it bring up any regret for you not being in

(location)? Like a feeling that you could have stopped him or helped him if you were there” (T43)?

Therapist responses that appeared ambiguous in reflecting fact or emotional information occurred at the end of the session when the therapist reflected that the client talked before about carrying stress in his back. More specifically, the 1 response (1%) consistent with *reflecting ambiguous fact/emotion* (FL3c) occurred when the therapist reflected that the client’s back pain seemed associated with stress because it hurts every time. In this session, content about somatization prompted ambiguous fact/feeling references. The one response (1%) that was consistent with *open-ended questioning on ambiguous emotional/factual content* (FL4amb-O) is illustrated in this example of when the therapist inquired about the client feeling stress after the suicide of his brother. The therapist asked, “What about for you? You know, your dad’s carrying extra stress. Are you carrying extra stress” (T71)?

Lastly, there were no responses consistent with *reflecting emotion* (FL3b), *open-ended questioning on factual content* (FL5aF-O), *closed-ended questioning on ambiguous factual/emotional content* (FL4amb-C), *trying to solve by giving advice/personal opinion* (FLTS-A), *trying to solve by using intervention strategies* (FLTS-I), and *ambiguous means of trying to solve* (FLTS-amb). Furthermore, of the 97 therapist talk turns coded in Participant 1’s early session, neither responses in which the therapist *verbalized positive changes that the client identified as already present* (LGA) or in which the therapist *reframed the way the client viewed certain events* (LGB) were identified. The therapist also did not use any responses consistent with Recommendation #3 *Events that are Too Horrible* or Recommendation #4 *Choosing the Right Words*.

Later session. The researchers coded a total of 165 therapist trauma discussion talk turns in Participant 1's *later* session (session 12, dated 6/09/09). Of these 165 talk turns, the researchers again coded the majority of codes, 113 responses (68.5%), consistent with *minimal encouraging* (FL1). Similar to Participant 1's early session, minimal encouraging responses occurred throughout the session.

The next most frequent codes also involved those around *closed-ended questions about factual information* (FL4cF-C, 14 responses, 8.5%), including about the current nature of client's relationship with his girlfriend, which had previously been described earlier in treatment as chaotic and a source of worry for the client. Other areas of factual inquiry included about the client's complaints of pain in his hands and back, increased marijuana use as a means to cope with his physical pain, and how he had been able to focus at work with all of his worries. Near the end of the session the therapist inquired about the client's self-care practices. Three (1.8%) of the therapist responses about factual content were *open-ended* (FL4aF-O) and 3 responses (1.8%) were consistent with *closed-ended questioning on ambiguous factual/emotional content* (FL4amb-C).

Also similar to the first session, the therapist *reflected factual* information (FL3a) as the third most common response (eight responses, 4.8%). For example, as the client talked about his original plan of living alone and his more recent decision to allow his girlfriend to live with him, the therapist reflected that his original plan was to live alone. This response prompted the client to discuss the reasons for his new decision. The therapist also reflected that the client had many things to focus on— talking to family, his art gallery, work—and that he had been able to accomplish these tasks during the past two weeks because his girlfriend had been compliant with her medication and even helpful to him, rather than behaving chaotically in which he would

typically worry about her. The therapist also reflected that the client attempted to practice healthy ways to take care of himself now rather than cope using drugs and isolating from others like during the time when his other brother died. Thus the therapist reflected the client's plans of how he was coping and taking care of himself.

Unlike with responses related to factual content, few of the therapist responses involved questioning on or reflecting the client's emotions: 1 response (0.6%) was consistent with *reflecting emotion* (FL3b), 1 response (0.6%) was consistent with *reflecting ambiguous fact/emotion* (FL3c), 2 responses (1.2%) were consistent with *open-ended questioning* on the client's *emotional content* (FL4bE-O), 1 response (0.6%) was consistent with *closed-ended questioning on emotional content* (FL4dE-C), and zero responses were consistent with *open-ended questioning on ambiguous emotional/factual content* (FL4amb-O). For example, when the therapist reflected the client's emotions (FL3b), it concerned the client not feeling comfortable with the unknown of what could be physically wrong with his body and cause of his arm and hand pain.

In contrast with the earlier session, there was an increase in Participant 1 making *Trying to Solve* responses. Specifically, 5 of the therapist responses (3%) were consistent with *trying to solve by using intervention strategies* (FLTS-I), which occurred toward the middle and end of the therapy session. In the following three examples, the therapist encouraged the client to seek medical attention regarding pain in his hands ("It definitely sounds like something you need to get checked out." [T69]), use mindfulness practice to help him manage his worries and anxiety ("Actually if you enjoy this I also have a book on grieving mindfully. That might be something to think about with all the losses that have gone on for you." [T103]), and to look into possibly utilizing medication programs:

Yeah, but I mean medications, there are discount medication programs out there that you can get into. If you tell the doctor that if you need generic drugs instead of, you know, brand names they'll find you those, and those are generally you know \$4 for a month's worth. (T129)

Two of the therapist responses (1.2%) were consistent with *trying to solve by giving advice/personal opinion* (FLTS-A), which occurred toward the end of the session. This example was the therapist's response to the client's thoughts about other people having far worse problems than his own. The therapist said, "I don't think it's fair to compare to others" (T163). There were no responses coded as *ambiguous means of trying to solve* (FLTS-amb).

For codes that were used to capture therapist responses indicative of *Labeling Growth When It is There*, there was 1 response (0.6%) in which the therapist *verbalized positive changes that the client identified as already present* (LGa), and 2 responses (1.2%) in which the therapist *reframed the way the client viewed certain events* (LGb). Toward the end of the session, when the client stated that there are always reasons for him to not do something, such as go to the doctor about the pain in his arm the therapist, responded, "But I think you recognize they're just excuses" (T131, an example of [LGa]). The client responded, "Right, no that's why I'm learning to make myself a priority so that I don't use those excuses" (C131) In response to the client stating that he wants to live a happy life and learn to take care of himself better, especially after watching his mother take care of others but not take care of herself, the therapist responded with the following two responses (1.2%) in which the therapist *reframed the way the client viewed certain events* (LGb):

- T158: I mean to a certain extent you have to go okay, I have to take care of myself.
- T161: Well in order to have the strength to be able to give to others and to help others, you have to be somewhere yourself where you're centered where you're

through all lot of – I mean you don't have to be the perfect person, everything in life doesn't have to be perfect, but you do have to have room for someone else.

Summary. In conclusion, out of a total of 218 therapist talk turns across 2 sessions for Participant 1, the majority of therapist responses were consistent with Recommendation #1 *Focus on Listening Without Trying to Solve*. Specifically, *minimal encouraging* responses were used the most as a means to focus on listening to the content the of the client's trauma discussions (FL1, $M = 97$, $SD = 22.6$), The therapist also utilized *closed-ended questions about factual* (FL4cF-C, $M = 12$, $SD = 2.83$) information, as well as *reflecting factual* information (FL3a, $M = 8.5$, $SD = 0.71$), to gain a better understanding of the client's familial and romantic relationships, thoughts about suicide, sources of worry and coping strategies, and how the client can best take care of himself.

The therapist rarely inquired or reflected the client's emotions, but when doing so evidenced a tendency to *question* about the client's *emotions* (FL4bE-O, $M = 2$, $SD = 0$; FL4dE-C, $M = 2.5$ $SD = 2.12$) more so than *reflecting* his *emotions* (FL3b, $M = 0.50$, $SD = 0.71$). The therapist tried to help the client solve problems using *intervention strategies* (FLTS-I, $M = 2.5$, $SD = 3.54$) such as introducing mindfulness meditation, in the *later* session rather than the *early* session.

Consistent with Recommendation #2 *Labeling Growth When it is There*, the therapist once verbalized (LGa, $M = 0.5$, $SD = 0.71$) and twice reframed (LGb, $M = 1$, $SD = 1.41$) positive changes the client made including learning to make himself a priority rather than neglecting his self-care to take care of others. These statements occurred in the *later* session only, which may be due to growth the client experienced over the course of treatment. Neither of Participant 1's

sessions evidenced therapist responses derived from Recommendation #3 *Events That are Too Horrible*, or Recommendation #4 *Choosing the Right Words*.

Participant 2

Early session. The researchers coded a total of 178 therapist talk turns in Participant 2's *early* session (session 6, date 11/20/07). Of these 178 talk turns, the therapist responded to the client's discussion to trauma the most using *closed-ended questioning about factual information* (FL4cF-C, 59 responses, 33.1%). This included discussion about the thoughts that went through the client's mind when she felt angry at her mother, if she had ever planned to hurt her mother when her mother acted violently toward her, if she thought about acting out in a violent manner like other members of her family, as well as details about incidents of violence such as when the client's mother tried to stab her with a knife. The therapist also clarified factual information about the client's family relationships. Examples follow that illustrate some of the therapist's closed-ended questions about facts to better understand the client's situation about her sisters living with their mother:

- T104: Are they with your adopted parents too?
- T105: Did you say they all live at home together?
- T131: What about, have you thought at all about, remember we talked about, um, you know, if you killed yourself, then who would be there for your sisters, right?

Of note, there were more *closed-ended* questions used than *open-ended questions* about factual content (FL4aF-O, 18 responses, 10.1%). These examples illustrate the open-ended questions the therapist used about how the client would react if her mother acted violently toward her:

- T214: What do you think about it?

- T223: If she started yelling at you or approaching you and was aggressive, what would you do? What would be your first instinct to react to her?

Questioning about the client's thoughts and situations were always followed up with the therapist reflecting what the client had responded, as well as more questions to clarify.

The next most common way the therapist related to the client's discussion of trauma was by using *minimal encouraging* (FL1, 53 responses, 29.8%), which occurred throughout the session. Of note, the researchers coded 1 response (0.6%) consistent with *direct encouraging* (FL2). The following is an example of a response coded as FL2 from the discussion about the client's sisters and her feelings about them leaving. The therapist said, "Okay, okay. Um, why don't you tell me a little bit about what's going on with your sisters leaving and how that went, because we haven't really talked about that" (T99).

Reflecting factual information to the client (FL3a, 44 responses, 24.7%) often followed the client's responses to the therapist's questions about factual information. The therapist's reflections during the client's discussion of trauma included reasons the client did not want to kill herself, such as because she would not be alive for her sisters to rely on for emotional support, as well as how she copes when she feels sad or angry.

The therapist also used closed-ended *questions* (FL4dE-C, 6 responses, 3.4%,) and *reflected* the client's *emotional content* (FL3b, 14 responses, 7.9%) such as asking the client where she feels her emotions in her body, such as when she feels angry or when she feels like crying. Again, when inquiring about the client's emotions, the therapist often reflected what the client had responded, and asked more questions about the client's emotions (hence the similar amount of reflecting and questioning on emotion therapist responses). Only one question about the client's *emotions* was *open-ended* (FL4bE-O, 0.6%). The therapist also engaged in several

talk turns in which she *reflected* (FL3b) that the client was afraid that she was going to do something violent one day, but by exploring the “evidence” of this using factual inquiry with the client, the client acknowledged that she had never acted violently toward her mother no matter how violent her mother was toward her, and that her fear was likely unfounded. In another example, the therapist also reflected that the client was feeling a lot of anger toward her mother for how her mother currently treats her sisters. When inquiring about the client’s emotions, the therapist also explored with the client why she did not feel “crazy,” and what the client’s behaviors said about her, specifically, that she does not act violently or “crazy” like her mother and aunt.

When coding for responses in which the therapist *Labeled Growth When It Was There*, 16 responses (9%) in which the therapist *reframed the way the client viewed certain events* (LGb) were indicated. In the following examples, the therapist reframed the client’s previous fights with her mother as acting in self-defense rather than because she is a violent person like her mother:

T245: Well why do you think, let’s see were talking about you know that you’re different than your family right? And that, in all these years you had all these opportunities that you could’ve been violent if you wanted to and you told me like a few, when most of them it sounds like most of them were related to defending yourself even though of course like when you’re a kid that wouldn’t be the way that we want to handle that, hurting another person, but, but you didn’t, you didn’t just take things out on people with violence, even with (C’s Husband) for example. So what do you think, what does that mean about you?

T252: I know. But what I’m trying to tell you though is that you’re right, of course think about that, if you’re a good person why would somebody do bad things to you. But C, what I’m trying to say is that not everybody can still get through all those things they way you got through them.

T253: That’s what’s so amazing and great about you and what you should feel so, that’s why it says about you, that you’re a good person. And you got through these things and you, you have maintained these beliefs about yourself that I am different than them, that

is so hard to do and you've done it. That's something, that's something that you should be so proud of yourself for.

Three responses (1.7%) in which the therapist *verbalized positive changes that the client identified as already present* (LGa) were also identified. In these examples the therapist verbalized the positive changes of how the client does not act in violence despite the environment in which she grew up:

T181: You know, I need to, I'm telling you that you're saying something very important right now. You're saying that from your side, you recognize that you're different than your family, they're crazy, [T make air quotes around 'crazy'] sounds like, I mean not even in quotes, they sound crazy and they do terrible things and they think its okay to hit their own children and you're, you say you're just not like that, you don't believe that way and thank God you don't. And that, on the other side, they see you, they also know that you're different. But they say it's a negative thing, but you, that you're so angry, and that, you know, cause you do all these things, but that you're, you're not believing what they say, it sounds like. They said that to you but you still believed about yourself, no I'm the good person here. I'm not angry.

T196: So in 21 years, one time you got really angry, you got violent, and you did it in self defense, you didn't, um, sounds like you didn't, she was starting a fight you didn't just get angry and then go after someone for no reason, right?

The next most common way the therapist related to the client's discussion of trauma was through reflecting the client's emotions. The therapist *reflected emotional content* (FL3b, 14 responses, 7.9%) more often than asked questions about the client's emotions. The following examples illustrate the therapist reflecting the client's emotional experience (as well as factual content) after the client described the physical and emotional abuse she experienced at the hands of her mother:

T163: Well what I hear, you know, what I'm hearing you say are a number of things. One is that obviously, just, I mean I know it was very hard for you, looks like it was hard for you to say that to me, I'm glad that you said it because its, its must be, it seems very painful, obviously I know, that somebody could do this to you and then you had to experience that. The other thing is that its your, you were saying, that its your own mom. It's your own mom. But I also feel like I'm kind of hearing or sense that maybe you feel like you're the older one, that you could take it, maybe it felt like you had to for your sisters and that you're worried.

When the therapist asked questions about the client's emotional content, closed-ended questions were used the most (FL4dE-C, 3 responses, 3.4%). One response (0.6%) was consistent with *open-ended questioning* on the client's *emotional content* (FL4bE-O), and one response (0.6%) was consistent with *closed-ended questioning on ambiguous factual/emotional content* (FL4amb-C). The following example illustrates the ambiguous nature of if the therapist inquired about a thought or a feeling:

T204: Okay. So, what about when you're fighting with (C's Husband), have you ever felt like you're gonna do something, I mean I know you feel like throw things sometimes right? But do you ever, do, have you ever felt like you're gonna hurt him, like try to hurt him?

Also regarding ambiguity, one response (0.6%) was consistent with *reflecting ambiguous fact/emotion* (FL3c). An example is the therapist's response to the client describing that her husband's calm demeanor helps her to calm down is provided. The therapist said, "So it helps to bring you down" (T made a descending motion with flat hand in front of body; T207). There were no therapist responses consistent with *open-ended questioning on ambiguous emotional/factual content* (FL4amb-O).

As part of the problem-solving component of the *Focus on Listening Without Trying to Solve* codes, 2 of the therapist responses to the client's discussion of trauma (1.1%) were consistent with problem-solving that entailed *trying to solve by using intervention strategies* (FLTS-I). The therapist did not relate to the client using *advice/personal opinion* (FLTS-A), nor evidenced a response consistent *ambiguous means of trying to solve* (FLTS-amb).

One response in which the therapist *chose to label or identify client statements reflecting posttraumatic growth with words that reflected the individual's struggle to survive and come to terms with the event, as opposed to the event itself* (CWb) was coded (the only one across all five

participants). The CWb response (1%) was expressed when the client discussed her fear of acting violently toward someone because of the violence her mother inflicted on her. Her “attitude” that she refers to in this next example is the anger and words she would use toward her mother and aunt when they were abusive toward the client, physically and emotionally. She still acknowledged however that she would never behave like her mother and aunt, and would never treat children or adults like how they treated her:

C181: I might not be a really good person cause I got my attitude, I guess from them, I don't know, I got my attitude, but I'm not like thinking what they do. They think that, you know.

T182: But do you think that having an attitude makes you not a good person? Cause what you're saying to me right now, you, you're a very good person. You have very, what you're saying to me is like very strong moral beliefs about not hurting other people, caring for them, standing up for yourself. C, so many people struggle with those things. And you're saying you did that even as a child, even in the midst of all this craziness and people telling you that it was bad to be that way and you still said, “Nope, I still know that that's right and I'm a good person.”

Later session. The researchers coded a total of 103 therapist talk turns in Participant 2's *later* session (session number unknown, dated 4/03/08). Of these 103 talk turns, the most common way the therapist related to the client was through *reflecting fact* (FL3a, 31 responses, 30.1%), followed by *closed-ended questioning on factual content* (FL4cF-C, 25 responses, 24.3%). Following questions, the therapist often reflected the client's responses such as how the client felt in the session talking about her mother's violent behaviors toward her sisters, her feelings about what it would be like to have friends, and how she would feel if she sent her sister a card for her birthday and kept in touch. The therapist inquired about the client's thoughts and situations, such as what influenced the client's decision to want to make friends, what was helpful for the client about being busy at work, if thoughts of suicide occur during the day (T125:

“Do those thoughts come up ever during the day?”) and what her concerns were about her sisters’ safety.

The therapist used *open-ended* questions about factual content less often than *closed-ended* questions (FL4aF-O, 14 responses, 13.6%). An example of an open-ended question on factual content is illustrated when the therapist asked the client more about her decision in which she talked about wanting to have friends: “Do you wanna tell me a little bit about, when you’re saying I’m working on the friends thing, have you been thinking about that lately” (T84)?

The next most common therapist responses next to closed-ended questions about factual content were consistent with *minimal encouraging* (FL1, 21 responses, 20.4%), which occurred throughout the session. The therapist responded with the verbal form of minimal encouraging such as “Right” and “Mm hmm,” in conjunction with the nonverbal form of minimal encouragement such as nodding. Of note, 1 response (1%) was consistent with *direct encouraging* (FL2).

Though not as frequent as reflecting and questioning on factual information, the therapist reflected and questioned about the client’s emotions, especially during the discussion about how the client would feel if she kept in closer contact with her sisters as well as how the discussion was making her feel in the moment when talking about the anger and uneasiness she feels about her sisters living with their violent mother and aunt. The therapist then reflected back to the client how she was feeling. Thus 4 responses (3.9%) were consistent with *reflecting emotion* (FL3b), 4 responses (3.9%) were consistent with *open-ended questioning* on the client’s *emotional content* (FL4bE-O), and 4 responses (3.9%) were consistent with *closed-ended questioning on emotional content* (FL4dE-C). Two responses (1.9%) were consistent with

reflecting ambiguous fact/emotion (FL3c). Examples of open and closed-ended questions about the client's emotions from this particular discussion of trauma follow:

- (Open-ended) T139: How do you think you'll feel if you are able to, to contact her [client's sister] in that way, send her something in the mail?
- (Closed-ended) T102: Does it feel kind of unsettling, a little bit?

In this next example, a response in which multiple codes illustrate when the therapist reflected and questioned about the client's emotional and factual content (FL3a, FL3b FL4cF-C, FL4dE-C) during the discussion of the client's ambivalence about having friends is illustrated:

T105: (FL3b) Well I think, when you're saying it feels confusing, you know like maybe unsettling or something like that, (FL3a) I mean with what you just said like your whole life that you're used to just being by yourself and just you know not needing anyone and so I think, like I said, for any change can feel funny, right. Cause this is a change in your own self, right. (FL3a) You're having a new thought and it's kind of, (FL3b) it must feel like scary in a way, (FL3a) because it's not something that you have had experience with. (FL4cF-C, FL4dE-C) Would that be right?

The therapist did not evidence any responses consistent with *closed-ended questioning on ambiguous factual/emotional content* (FL4amb-C) or *open-ended questioning on ambiguous emotional/factual content* (FL4amb-O) in this session. This therapist may not have spent as much time relating to the client's emotions in this particular session because it appears that she may have been focused on questioning and reflecting the client's thoughts as well as cognitive behavioral interventions that focused more on thoughts than feelings.

For the *Trying to Solve* component of the recommendation *Focus on Listening without Trying to Solve*, the therapist also evidenced 4 responses (3.9%) consistent with *trying to solve by using intervention strategies* (FLTS-I). This included encouraging the client to maintain contact with her sister as well as psychoeducation about the therapeutic process such as using the therapist-client relationship as a positive example for how to relate to other individuals and learn

to trust them, outside of the therapy session. In the following example, the therapist encouraged the client to call her sister to build and keep their relationship: “And do, I mean, and I think, when it comes to your little sister I think, the best thing, what you keep doing is you stay in contact, so she knows she can call you” (T172). Within the discussion about keeping closer contact with the client’s sisters, 3 responses (2.9%) were consistent with *ambiguous means of trying to solve* (FLTS-amb):

- T145: Right. Well I think it sounds like, I mean I like the idea calling your sister or sending her a watch, something that she’s been wanting cause it’s like when you are feeling that she is so far away it’s hard not to be with her on her birthday, I’m sure she misses you a lot too, and it’s like, I think it’s great for both of you, when you’re able to, that’s a surprise, it’s so special to get something, like when you get stuff from your parents.
- T147: Yeah. And so it’s the same, it’s the same for your sister, I’m sure they probably feel, your parents feel good sending you stuff, you’ll feel good sending your sister a present.

Of note, the therapist did not evidence any responses of *trying to solve by giving advice/personal opinion* (FLTS-A).

In this particular session, there was an increase in this therapist’s use of responses in which she *verbalized positive changes that the client identified as already present* (LGa, 7 responses, 6.8%), but a decrease in frequency of responses in which she *reframed the way the client viewed certain events in a new, positive way* (LGb, 3 responses, 2.9%). For example, when the client stated to the therapist that she had been working and was now thinking that she

might want to have friends and close relationships (in addition to her husband), the therapist verbalized the positive change of the client now considering friendships:

(LGa) T87: But I mean, very, I mean this is the first time I've ever heard you say, "I think I would like to have friends sometime," I've never heard you say that before. [Client laughs] That's a big deal.

Continuing the discussion about the client wanting to have friendships and struggling with her ambivalence toward trusting other individuals, the therapist continued with the following LGb responses in which she reframed the way the client viewed her confusion as ambivalence:

- T88: That's a new one, it's a big deal. So you know what that shows me is that you have, well it's like you said it's so confusing cause part of you feels like you don't want them but now there's a new part of you that's saying, "Well maybe I would like them, I might not be ready for it yet."
- T89: But I, but I might want that. What do you think about that? It's kind of this new part of you that's changing.
- T97: Well I mean, I have to say I'm very excited to hear you say that because I think it's a very, it shows that, like I said that you're learning, like you're learning to do, be comfortable with yourself and to trust other people and just the thought, even though, like you're saying, it still feels confusing, you don't feel ready which is more than understandable. The fact that you're even having the thought, "I think I might like them," I think is a huge, huge sign of how far you've come.

Within the same discussion about the client changing and becoming less ambivalent about wanting to trust other individuals, 1 response (0.07%) in which the *therapist reinforced the positive interpretations of growth or positive changes coming from the struggle with trauma when the client made them* (CWa) was indicated. This occurred during the discussion in which

the client and therapist talked about the client becoming more receptive to change, and continuing to learn through therapy how to learn to trust people outside of the therapy, such as new friends. The therapist said, “And you’ve really learned, but you’ve learned the ability to allow yourself to change, right” (T83)? In this session, there were no responses in which the therapist labeled or identified client statements reflecting PTG with words that reflected the individual’s struggle to survive and come to terms with the event, as opposed to the event itself (CWb).

Summary. Thus across both sessions for Participant 2 totaling 281 talk turns, the majority of therapists responses were consistent with Recommendation #1 *Focus on Listening Without Trying to Solve*. The most common type of responses used were *closed-ended questioning about factual information* (FL4cF-C, $M = 42$, $SD = 24$) as well as *reflecting factual information* (FL3a, $M = 37.5$, $SD = 9.2$) about the client’s family members, incidents about traumatic experiences such as her mother trying to stab her with a knife, and the client’s concerns and fears about having friendships and trusting individuals. Of note, the therapist used more closed-ended questions about facts than open-ended ones (FL4aF-O, $M = 16$, $SD = 2.82$). The next most common response used was *minimal encouraging* (FL1, $M = 22.6$, $SD = 24.04$) as a way to focus on listening to the client’s discussions of trauma. The therapist also asked questions about the client’s emotions (FL4dE-C, $M = 5$, $SD = 1.41$; FL4bE-O, $M = 2.12$, $SD = 2.12$) more than reflecting them (FL3b, $M = 9$, $SD = 7.1$), including how the client felt in session as she talked about her traumatic experiences, her suicidal feelings, and feelings of anger toward her mother. A few times, the therapist tried to help the client solve problems using intervention strategies (FLTS-I, $M = 3$, $SD = 1.4$), such as psychoeducation and learning to walk away when she is angry.

The therapist also used responses consistent with Recommendation #2 *Labeling Growth When it is There*. The therapist evidenced more responses in the *later* session in which she verbalized positive changes the client made toward allowing herself to trust other individuals and seek friendships (LGa, 7 responses) and more LGb responses in the *early* session in which she reframed the client's view of her actions as positive (LGb, 16 responses) such as fighting with her mother and aunt and being a "violent" person as responding to a traumatic situation in self-defense. Overall, the therapist for Participant 2 utilized the highest frequency of LGa and LGb responses when compared across participants in the study.

Lastly, the sessions for Participant 2 contained one of each of the codes for Recommendation #4 *Choosing the Right Words*. Although this represents a very small number of responses relative to the number of talk turns (281 talk turns across *early* and *late* sessions; CWa, 1 response; CWb, 1 response), this therapist was the only participant in the study who used these growthful responses to the client's discussion of trauma. Specifically, the therapist reframed that the client was generally not a violent person and acted in self-defense as a way to survive her abusive environment, and still managed to develop into a nonviolent person despite the environment in which she grew up.

Participant 3

Early session. The researchers coded a total of 276 therapist talk turns in Participant 3's *early* session (session 4, date 11/09/07). Of these 276 talk turns, the majority of therapist responses (213 responses, 77.2%) were consistent with *minimal encouraging* (FL1), which occurred throughout the session. These responses took the form of verbal responses such as "Mmm hmm" as well as the nonverbal form of minimal encouragement such as nodding.

The next most common response was consistent with *reflecting fact* (FL3a, 26 responses, 9.4%), followed by *questioning about factual content*. The therapist's reflections included responses about how the client lives within two competing cultures as he tries to acculturate with American culture, as well as having a lot of pressure of other's thoughts and concerns for the client to live and marry within his Turkish community. In the following examples, the therapist reflects back what the client says about his concern with his family living back home in Turkey.

- T53: So you're worrying about her, worrying about you.
- T183: So maybe because other people are branching out you think that your family...would be more willing to...come here.

The therapist asked more closed-ended questions about factual content than open-ended questions. The therapist's questions about factual content included 21 responses (7.6%) consistent with *closed-ended questioning on factual content* (FL4cF-C). This example is from the same discussion in which the client and therapist talk about the client's worries about his mother. The therapist said, "Yeah. And in this past week were there certain times where this was on your mind, more than others" (T228)?

Ten responses were consistent (3.6%) with *open-ended questioning on factual content* (FL4aF-O), including what it would mean to the client to stay in the United States as opposed to moving back to Turkey, what his community is like, times he becomes anxious thinking about family and home, and what would help him to make his decision about leaving or staying in the United States. The following examples are therapist responses to the client talking about his decision to stay in America versus moving back to Turkey:

- T57: Mm-hmm. Why do you think it's come up now?
- T149: Now what is your community like here?

The next most frequent response included *reflecting* the client's *emotions* (11, 4%, FL3b) such the client feeling comfort to know that his mother would rather see him happy living in the United States rather than unhappy living in Turkey, hurting the client every time he sees his mother cry because it makes him feel guilty for not living closer to her, feeling worried about upsetting his family such as his aunt crying when she had a dream that he married an American girl, and feeling unhappy if he went back to Turkey because he prefers to continue living in America. The following example is a therapist reflection of the client feeling relieved that his mother would rather him live in the U.S. and feel happy rather than move to Turkey feel unhappy:

- C29: But, then she told me that, you know "I don't wanna see you come here and be unhappy, I'd rather see you stay over there and be happy."
- T31: That must have been, in some way, comforting.

Five responses (1.8%) were consistent with *reflecting ambiguous fact/emotion* (FL3c), such as, "It sounds like this past week you struggled a lot with this issue" (T226). Although this therapist reflected the client's feelings more often than inquiring about them, when relating to the client's emotions during this session, the therapist inquired about them using more *open-ended* questions than *closed-ended* questions. Seven responses (2.5%) were consistent with *open-ended questioning* on the client's *emotional content* (FL4bE-O), including how the client would feel if he told his mother and sister that he wanted to remain living in the United States as opposed to moving back to Turkey, his idea about having his family move to the United states, and what feelings come up for him when he thinks about moving back. Two examples follow:

- T23: Mm-hmm. Mm-hmm. And how would you feel if, if you wanna, if you said "I wanna stay here," and you know that she wants you to go back?

- T117: [T nods] Mm-hmm. How do you feel about that?

Three responses (1.1%) were consistent with *closed-ended questioning on emotional content* (FL4dE-C), and appeared in the same discussion about the client's thoughts about leaving or staying in the United States. The following is an example: "Did it make you feel better at all to hear your mom say that she...you know...doesn't want you to make the decision for them" (T39)?

Also, 3 of the therapist responses (1.1%) were consistent with *closed-ended questioning on ambiguous factual/emotional content* (FL4amb-C). Two examples follow:

- T134: So you feel like there's no compromise there? Because you feel very strongly about your values.
- T245: Because you feel like you'd need to take care of both of them at that point?

There were no responses consistent with *open-ended questioning on ambiguous emotional/factual content* (FL4amb-O).

When the therapist *tried to solve by using intervention strategies* (1 response, 0.4%, FLTS-I) she attempted to help the client problem-solve to increase time spent with his mother in order to help alleviate some of the anxiety and guilt he felt about not living closer to her: "Or maybe your sister could help also and maybe help support you, even though she is over there and help with your mom and making her a little less anxious about you being here" (T243)?

There were no *trying to solve by giving advice/personal opinion* (FLTS-A), or *ambiguous means of trying to solve* (FLTS-amb) therapist responses in this session.

Also in this session, there were no responses in which the therapist *verbalized positive changes that the client identified as already present* (LGA) or *reframed the way the client viewed certain events* (LGB) was indicated. Lastly, there were no responses consistent with

Recommendation #3 *Events That are Too Horrible* or Recommendation #4 *Choosing the Right Words*.

Later session. The researchers coded a total of 241 therapist talk turns in Participant 3's *later* session (session 6, dated 2/01/08). Of these 241 talk turns, the majority of responses were consistent with *minimal encouraging* (FL1, 184 responses, 76.3%), which occurred throughout the session.

The next most common therapist responses were those in which the therapist related to the client's discussion by reflecting the client's *factual content* (FL3a, 43 responses, 17.8%). In this session, the therapists reflected factual content such as the client's thoughts during his decision making process and his steps toward taking action to help himself figure out what he wants, such as with a woman with whom he went on a date and refusing to "play games" with her. Other times this code appeared included when the client stated that he needed to change so that he can be less anxious and more relaxed regarding his grades and his performance in school, he stated that he needs be more self-accepting, self assertive, and did not want to judge himself so much because some things are not all his fault and he cannot win everything. The therapist reflected that the client cannot have control over everything, and that he is starting to modify his beliefs that he must do everything "right." When the client realizes that he is over-reacting to not getting perfect grades, the therapist reflected: "Mm-hmm, [T nods] mm-hmm, and you're realizing this and trying to change some of those reactions" (T209). Regarding the client's thoughts about his difficulties with learning and well as wanting help with his accent and that if he takes care of this it will reduce his frustration, the therapist reflects that the client is figuring out what he wants and is taking steps to change his situation.

In addition to reflecting factual content, the next most common type of therapist response was asking *closed-ended questions* about the client's *factual content* (FL4cF-C, 12 responses, 5%). The therapist asked questions about the client's values that he holds to be important in determining how he wants to live his life while merging two cultures, focusing on what the client views as important such as the kind of woman he would like to marry rather than worrying about what others think or would want for him, his process of assimilating to American culture, as well as his focus on his grades and school grades without having too much worry to stifle his performance. The majority of questions about factual information occurred toward the end of the session when trying to figure out if client wanted to continue coming to therapy, and taking action toward what he wanted, which was "less talking and more doing" such as going to school and getting psychological testing for his learning difficulties. Compared with closed-ended questions, there were much less therapist responses consistent with *open-ended questioning on factual content* (FL4aFO, 3 responses, 1.2%). An example from the discussion of the client talking about his decisions to try to relax more and be less perfectionistic about school follows: "Mm-hmm, what do you think some of the—how did you, you know, go through this transformation in the last couple weeks? How did you come to these decisions, and what do you think influenced you" (T162)?

The next most common response was that in which the therapist made 8 (3.3%) *verbalized positive changes that the client identified as already present* (LGa) responses. In the following LGa examples, the therapist responded to the client's preference to stay in the United States by reframing it as a process of self-exploration and decision-making:

- T109: Mm-hmm. It sounds, you know, like a process. You're trying to, you're trying new things, going to a different place, and seeing where it takes you and, you know...

- T160: Right, it sounds like you know, this past couple of weeks, [T nods] you've really you know, looked inside yourself, and a lot of self realization.
- T161: And you know, where you were not wavering at some decisions, you decided you know, I want to be happy, [T nods] and being happy means I want you know, to take care of myself.

For 7 responses (2.9%) the *therapist reframed the way the client viewed certain events in a new, positive way* (LGb) within this discussion about the client's process of exploring his thoughts and feelings about his cultural values and decision to stay in the United States:

LGb T69: Mm-hmm, well it sounds like, you know, the past couple of weeks you've really been asking yourself a lot of questions, when you're in these situations, and focusing on what, you know really just focusing on just what you want.

LGb T172: Right, and it sounds like when you were talking and telling me some of you know the stories and things happening, you, you know, named some of the automatic thoughts when you were thinking, and so you were just more aware of those, and able to kind of deal with them.

For the next most commonly used therapist response in this session, when discussing the client's emotions, the therapist asked questions more often than she reflected them. For example, the therapist asked *open-ended questions* about the client's *emotional content* (5 responses, 2.1%, FL4bE-O), such as how the client felt to be from another cultural community pursuing his own career and going to school, how he felt about wanting to separate himself from previous friends from his community who have different values that he does, how he felt about how individuals in his community might perceive him, how he had come his decisions, and what influenced him to make those decisions about pursuing his goals despite what others in the community and family may want for him. To a lesser degree, the therapist responded to the client's discussion by *reflecting emotions* (FL3b, 4 responses, 1.7%). In response to the client stating that that he felt better about having a future in the United States and that he felt confident

that he could accomplish his goals and needs here, the therapist reflected the following feeling (FL3b): “Mm-hmm. [T gestures with hands] It must have been somewhat of you know, of relief to make that decision” (T17). The therapist also evidenced 7 responses (2.9%) consistent with *reflecting ambiguous fact/emotion* (FL3c). Of note, there were no therapist responses consistent with *closed-ended questioning on emotional content* (FL4dE-C), *closed-ended questioning on ambiguous factual/emotional content* (FL4amb-C), or *open-ended questioning on ambiguous emotional/factual content* (FL4amb-O).

For the problem-solving component of *Focus on Listening Without Trying to Solve*, 2 responses (0.8%) were consistent with *trying to solve by using intervention strategies* (FLTS-I). For example, the therapist spoke with the client about psychological testing when he talked about wanting to take steps toward looking into a possible learning disability:

T196: Yeah, cause some of the things that they can do for you is you know, recommend services and then also you know, more time if it involves reading comprehension on tests, or you know, things like that. So I think that can be useful.

One response (0.4%) was consistent with *trying to solve by giving advice/personal opinion* (FLTS-A),

T212: [T nods] Mm-hmm. (2) So is there – You know, I of course [T gestures with hands] love to see you, so I encourage you to come as much as you can. [C wipes eyes] Why don't we make a plan that I check the messages on Wednesday nights, [T gestures with hands] if you want to meet on Friday? Does that sound?

Lastly, zero responses were consistent with *ambiguous means of trying to solve* (FLTS-amb).

Summary. In sum, across both sessions for Participant 3 totaling 517 talk turns, the therapist related to the client the most using responses consistent with Recommendation #1 *Focus on Listening Without Trying to Solve*. The therapist used *minimal encouraging* responses the majority of the sessions (FL1, $M = 198.5$, $SD = 20.5$). The therapist's next most common response was *reflecting factual* information (FL3a, $M = 34.5$, $SD = 12$) including the client's

thoughts and concerns about moving back to Turkey out of worry and concern for his family as well as his desire to remain in the United States. The therapist also *questioned* about the client's *factual* content (FL4cF-C, $M = 16.5$, $SD = 6.4$; FL4aF-O, $M = 6.5$; $SD = 5$) related to his difference in experience with Turkish and American culture, his worries about his perfectionistic thinking related to his school work, and what influenced his decisions to remain in the United States despite his worry about his family.

The therapist also asked *questions* about the client's *emotions* (FL4bE-O, $M = 6$, $SD = 1.4$) and *reflected* the client's *emotions* (FL3b, $M = 7.5$, $SD = 5$), though not nearly as often as relating to factual content. When the therapist did ask or reflect the client's emotional content, such responses inquired about how the client would feel if he made particular decisions, and how he would feel about his family member's reactions to those decisions. As for *trying to solve*, the therapist twice attempted to help the client solve problems using *therapeutic interventions* (FLTS-I, $M = 1.5$, $SD = 0.71$) rather than advice giving; specifically educating the client about psychological testing as well as problem-solving about how to increase contact with his mother in order to decrease his worry about her living in another country.

For Recommendation #2 *Labeling Growth When it is There*, the therapist used both responses congruent with *verbalizing* (LGa, $M = 4$, $SD = 5.7$) and *reframing* (LGb, $SD = 5$, $M = 3.5$) *positive changes the client made* in the *later* session, but not in the earlier session. The therapist related to the client's discussion with these responses about his process of exploring his thoughts and feelings about his cultural values and decision to stay in the United States. The therapist's increased use of LGa and LGb codes in the later session may be indicative of the client's growth over time. Lastly, there were no responses consistent with Recommendation #3 *Events That are Too Horrible* or Recommendation #4 *Choosing the Right Words*.

Participant 4

Early session. The researchers coded a total of 132 therapist talk turns in Participant 4's *early* session (session number unknown, date 1/23/07). Of these 132 talk turns, the most common response was consistent with *minimal encouraging* (FL1, 47 responses, 35.6%), which occurred throughout the session. The next most common way of relating to the client was through *closed-ended questioning about factual content* (23 responses, 17.4%), which occurred more often than *open-ended questioning on factual content* (FL4aF-O, 10 responses, 7.6%). Initially, therapist questions during the session were about the client's compulsive scratching of her back and stomach, and if her Cymbalta medication was helping to reduce her urge to scratch. The therapist also inquired about the client's frustrating experiences throughout the day that may have led to the scratching, and what else she had tried to cope with her scratching, including how using gloves has worked. Later in the session the focus of questions on factual content pertained to the client's upcoming eye surgery, including what would happen as a result of the surgery, and who would be there to take her to the hospital. Discussion about this prompted the therapist to ask for further details about the client's previous experience with having a stroke, including what her experience was with almost losing her foot and toes, as well as her experience of contracting MRSA, a staphylococcus infection, while in the hospital. Two responses (1.5%) were consistent with *closed-ended questioning on ambiguous factual/emotional content* (FL4amb-C) and 4 responses (3%) were consistent with *open-ended questioning on ambiguous emotional/factual content* (FL4amb-O).

The next most common therapist responses were consistent with *reflecting facts* (FL3a, 7 responses, 5.3%), and *reflecting emotions* related to the client's discussion of trauma (FL3b, 7 responses, 5.3%). The therapist reflected the client's factual content such as how drinking tea

helps the client calm down when she worries about her health condition and other challenges that occurred throughout the day related to her upcoming eye surgery. Often the therapist's inquiries and reflections about factual content such as thoughts and situations led to the therapist *reflecting* the client's *emotions*, which occurred more often than *questioning* about the client's emotions. For example, in asking the client about the logistics of her upcoming surgery, the client disclosed that her stroke had left her feeling helpless and unworthy of help from others, in which the therapist reflected the client's pain as well as that it was a similar feeling the client had growing up as an adopted child. In the following example, the therapist reflected how the client felt about her condition having had a stroke:

T128: You know it makes me think your feelings about taking up a bed at the hospital and not being really- worthy of having that bed and your feelings about being a burden to your friends and not really feeling like you deserve that seems to be, sort of a theme.

When questioning about the client's emotions, 2 responses (1.5%) were consistent with *open-ended questioning* about the client's *emotional content* (FL4bE-O) and 2 responses (1.5%) were consistent with *closed-ended questioning on emotional content* (FL4dE-C), such as her fears about her upcoming surgery including how it felt to need a walker as well as having felt like falling down all of the time after having her stroke, having to rely on others for her care, other times in the client's life when she had felt embarrassed and dependent on others, as well as not feeling worthy to receive their help, emotionally where her difficulty to receive help comes from, and if she still felt like in her adult life that she would lose friends if she needed something without returning favors. In this example, the therapist inquired about the client stating that she did not deserve a hospital bed: "Where is that feeling stemming from" (T131)? Lastly, 1 response (0.8%) was consistent with *reflecting ambiguous fact/emotion* (FL3c).

When coding the *Trying to Solve* component of the recommendation *Listening Without Trying to Solve*, 6 responses (4.5%) were consistent with *trying to solve by using intervention strategies* (FLTS-I). In the following examples, the therapist encouraged the client to try writing her thoughts in addition to drinking her tea when she feels the urge to scratch herself:

T57: So maybe we can put a step in the middle and have you write when you are feeling upset. Not for a long time but maybe just write down some of the things that are bothering you or maybe what's on your mind or just free flowing thoughts.

T62: So maybe if you know you are going through frustrating experiences write them down. Even when you are having your cup of tea, do a little writing and see where that takes you. Because maybe putting in a step in between, having you be more conscious of your frustrations and feelings of being upset, um, maybe if you bring it to the consciousness then you won't subconsciously start scratching.

The client was receptive to the therapist's suggestions. One response (0.8%) was also consistent with *trying to solve by giving advice/personal opinion* (FLTS-A). In this example, the therapist commented about her personal reactions to the client's eye surgery procedure: "It sounds very scary to me" (T81). No responses were consistent with *ambiguous means of trying to solve* (FLTS-amb).

Also in this session, neither response in which the therapist *verbalized positive changes that the client identified as already present* (LGa) or therapist *reframed the way the client viewed certain events* (LGb) was indicated. Lastly, there were no responses consistent with Recommendation #3 *Events That are Too Horrible* or Recommendation #4 *Choosing the Right Words*.

Later session. The researchers coded a total of 86 therapist talk turns in Participant 4's later session (session number unknown, dated 5/01/07). Of these 86 talk turns, the most common way of relating to the client's trauma was through *questioning about factual content* (FL4cF-C, 21 responses, 24.4%), such as how the client's surgery went, what her vision is like

now, what her plans are for her living situation as her vision deteriorates over time, and her thoughts about her friend/roommate's son's teenage independence behavior and how she perceived it as a threat to her security of having another person on which to rely for help. As the discussion about her friend's son progressed, the therapist inquired about if the client wanted children, which led to the therapist questioning about the client's emotions including exploring how her childhood experiences and fears had made her feel inadequate to raise children even though she felt confident about her abilities in being a nanny and taking care of children in that manner. An example illustrates:

T46: Okay so what you are saying is that because of who you are that you could never raise a child better than yourself and if you had a child, they would be badgered and teased and so forth because of the mother that you would be?

Notably, the therapist related to the client with more *closed-ended questioning on fact* responses than *open-ended* questions (FL4aF-O, 9 responses, 10.5%). The next most common therapist response was consistent with *minimal encouraging* (FL1, 20 responses, 23.3%), which occurred throughout the session.

The therapist also related to the client's discussion of trauma with responses consistent with reflections of facts and emotions (FL3a, 10 responses, 11.6%; FL3b, 10 responses, 11.6%). These responses took place during the discussion in which the client talked about feeling inadequate to care for children as well as the client's low self-esteem related to her experiences in childhood. An example follows:

T58: And that goes back to what we were sort of, what I mentioned before about the low self-esteem [client nodding]. The way you feel about yourself, makes you feel that you couldn't raise someone as good or better than yourself.

Four responses (4.7%) were consistent with *reflecting ambiguous fact/emotion* (FL3c). While less common than reflecting the client's emotions, the session began with the therapist

questioning about the client's emotions, including how the client was feeling following her eye surgery treatment and having blurry vision (FL4bE-O, 2 responses, 2.3%), as well as 2 responses (2.3%) consistent with *closed-ended questioning on emotional content* (FL4dE-C). Five responses (5.8%) were consistent with *open-ended questioning on ambiguous emotional/factual content* (FL4amb-O) and no responses were consistent with *closed-ended questioning on ambiguous factual/emotional content* (FL4amb-C).

For the *Trying to Solve* component, the therapist evidenced 4 responses (4.7%) consistent with *trying to solve by giving advice/personal opinion* (FLTS-A). The therapist used her personal opinion to relate to the client's thoughts and feelings about her inability to be able to adequately raise children despite her skill as a nanny. The following response illustrates the therapists' opinion/advice giving: [Client moving leg, and clenching lip] "But being a nanny is being responsible for a child having the right morals" (T39). The therapist evidenced 1 response (1.2%) consistent with *trying to solve by using intervention strategies* (FLTS-I) and no responses consistent with *ambiguous means of trying to solve* (FLTS-amb).

In this session regarding the *Labeling Growth When it is There* recommendation, the therapist *reframed the way the client viewed certain events* (LGb) in 2 responses (2.3%). In the following example, the therapist responded to the client's change in thoughts about her feeling rejected by her friend's son: "It sounds like you have a very good handle on what it is" (T32). Therefore, although the client previously felt rejected because of her friend/roommate's teenage son behavior of staying in his room, the therapist helped the client view his behavior as something that teenage boys do, rather than as personal toward her.

In this session, the therapist did not evidence any responses in which she *verbalized positive changes that the client identified as already present* (LGa). Also, there were no

responses consistent with Recommendation #3 *Events That are Too Horrible* or Recommendation #4 *Choosing the Right Words*.

Summary. Across both sessions for Participant 4 totaling 218 talk turns, the therapist primarily related to the client using responses consistent with Recommendation #1 *Focus on Listening Without Trying to Solve*. The most commonly used responses included *minimal encouraging* responses (FL1, $M = 33.5$, $SD = 19.1$) and *closed-ended questions about factual content* (FL4cF-C, $M = 22$, $SD = 1.41$). The therapist used *minimal encouraging* more often in the *early* session than in the *later* session, and *questioned* about the client's *factual* content more so in the *later* session than in the *early* session. This pattern may be attributed to the therapist listening to the client with minimal interjection during the initial trauma discussion, followed by becoming more actively engaged in the client's trauma discussion later in treatment. *Factual* information the therapist inquired about included details about the client's eye surgery, her previous stroke, and other health-related traumas she experienced. The therapist also asked *closed-ended questions about facts* more often than *open-ended questions* (FL4aF-O, $M = 9.5$, $SD = 0.71$). The therapist also related to the client's discussion of trauma by *reflecting factual* information (FL3a, $M = 8.5$, $SD = 2.1$) as well as reflecting the client's emotions (FL3b, $M = 4.5$, $SD = 3.5$). The therapist *reflected factual* information more so than emotions in the *later* session. Therapist reflections of factual discussion consisted of how the client used drinking tea to cope with her compulsive scratching as well as experiences related to her stroke. The therapist *reflected emotions* more often than factual content in the *early* session. Discussion of the client's emotions prompted the therapist to reflect how the client was feeling about having experienced a stroke, including the client feeling helpless and like a burden on others, fearful of losing her limbs and eyesight due to medical complications, and feeling inadequate to raise children.

Although used few times relative to the number of talk turns, *Trying to Solve* responses consistent with *therapeutic interventions* (FLTS-I, $M = 3.5$, $SD = 3.5$) were made in the client's earlier session, while the therapist relied on responses more consistent with personal *opinion/advice-giving* (FLTS-A, $M = 2.5$, $SD = 2.12$) as a means to help the client solve problems in the later session. Therapeutic interventions included encouraging the client to write about her thoughts and feelings that triggered her compulsive behavior to scratch herself, whereas advice-giving responses occurred during discussion of the client's thoughts and feelings about the responsibility required in raising children and working as a nanny.

For Recommendation #2 *Labeling Growth When it is There*, the therapist related to the client once by reframing positive changes the client made (LGb, $M = 1$, $SD = 1.41$) in the *later* session only. This concerned the therapist reframing the way the client started perceiving others' behaviors in a different light. No responses occurred consistent with Recommendations #3 *Events That are Too Horrible* and #4 *Choosing the Right Words*.

Participant 5

Later session. The researchers coded a total of 72 therapist talk turns in Participant 5's session (session 10, date unknown). Of these 72 talk turns, a majority of the responses 50 responses (69.4%) were consistent with *minimal encouraging* (FL1), which occurred throughout the session. There was also 1 response (1.4%) that was consistent with *direct encouraging* (FL2), "Can you tell me a little bit more about your friend" (T220)?"

This particular therapist also *reflected factual* and *emotional* content more than asking questions about it. Seven responses (9.7%) were consistent with *reflecting fact* (FL3a) and 7 responses (9.7%) were consistent with *reflecting emotions* (FL3b). The therapist responses within the client's discussion of his emotions in the session included how it was hard for him to

hear about his friend's death from his deceased friend's brother, especially because he was so young and had spent a lot of time with him, and how difficult the funeral was because the client found it hard to see the women cry. Additionally, 5 responses (6.9%) were consistent with *reflecting ambiguous fact/emotion* (FL3c). An example of an ambiguous fact/emotion reflection was used during the discussion about the client's experience of his friend's funeral, seeing the women cry: "Yeah. Mm-hmm. Yeah, it's really hard to deal with that" (T270). After the therapist reflected that the client had stated he would try to not think about his friend's death, she inquired if that was the way in which he had been dealing with it two months later.

Therapist responses that were *questions about fact* focused on how close the client was to his friend, and how he dealt with the funeral. Two responses (2.8%) were consistent with *open-ended questioning on factual content* (FL4aF-O), which occurred in the beginning of the session when the therapist inquired about how the client heard about his friend's death: [T nods] "Mm-hmm. Yeah. Do you remember, like what happened when you find out? Like how—like the situation, how it happened" (T236)? Two responses (2.8%) were consistent with *closed-ended questioning on factual content* (FL4cF-C) and 1 response (1.4%) was consistent with *closed-ended questioning on ambiguous factual/emotional content* (FL4amb-C). The following example occurred near the end of the session when the therapist inquired if the client was still trying to not think about his friend's death 2 months later: "Do you still feel like that's where you're at or has the way you feel about it changed" (T260)? The therapist evidenced 1 response (1.4%) consistent with *open-ended questioning on ambiguous emotional/factual content* (FL4amb-O). In the following example the therapist asks the client about his friend's funeral: "How did you deal with it" (T254)?

Of note, no responses were consistent with *open-ended questioning on the client's emotional content* (FL4bE-O), or *closed-ended questioning on emotional content* (FL4dE-C).

In this session, there were also no responses consistent with any of the Trying to Solve codes: *trying to solve by giving advice/personal opinion* (FLTS-A), *trying to solve by using intervention strategies* (FLTS-I), and *ambiguous means of trying to solve* (FLTS-amb).

The therapist evidenced 1 response (1.4%) consistent with Recommendation #2 *Label Growth When It Is There*, in which the therapist *reframed the way the client viewed certain events* (LGb). As the client was talking about his thoughts and feelings about the sudden death of his friend, and how it made him think about a lot of things, such as the inevitability of his parents' death, and death in general, the therapist responded: "Well it woke you up in some ways" (T291).

For Recommendation #3 *Events That are Too Horrible*, the therapist evidenced 1 response (1.4%) in which she *shared with the client that some individuals stated they have changed in some positive ways as they coped with their trauma* (EHa). This therapist response occurred near the end the session with the aforementioned LGb response when the client talked about his friend's sudden death, such as needing to think about it, including the pain and logistics of when people die, including that his parents will die one day, and that death is inevitable but something people do not think about.

T288: [T nods] Yeah. It's—it's very normal when we—someone close to us passes away to start thinking about all these things. I mean, people think about it from time to time anyways, but when these kind of things happen it kind of wakes us up.

C289: [C nods] Yeah I would say to a certain extent it did. You know what I mean?

In this session there were no responses with Recommendation #4 *Choosing the Right Words*.

Not Otherwise Specified

The *not otherwise specified* (NOS) category was constructed to capture therapist responses that did not fit under the theoretically derived codes, yet appeared relevant to Calhoun and Tedeschi's (1999) recommendations for promoting PTG. Across all 9 sessions of the 5 participants, a total of 100 talk turns were coded as NOS responses ($M = 12.6$, $SD = 5.3$).

Using the NOS responses, the author delineated 2 additional subcategories of *Recommendation #1 Focus on Listening Without Trying to Solve*, and 1 new category of responses that did not fit within the four Recommendations or within PTG theory. Table 8 is provided to more clearly illustrate the new subcategory and subcategories that will be described next.

Table 8

New Category and Subcategories Delineated From NOS Responses

REC 1 Subcategory Supportive Personal Opinions	REC 1 Subcategory Encouraging Responses	NEW Category Engaging through Opinions
	a. Empathic encouraging	a. Supportive disclosures
	b. Encouraging progress	b. Trying to convince
	c. Encouraging choice	c. Direct instruction opinion
		d. Medical opinion

For the first new subcategory of Recommendation #1, 72 therapist responses concerned *supportive personal opinion* statements, which involved the therapist focusing on listening to the client rather than using opinions as a means for trying to solve; thus it was considered a new subcode within the *Focus on Listening Without Trying to Solve* recommendation. These responses could not be coded as opinion/advice-giving (FLTS-I) because these opinion statements were viewed as supportive to what the client described, as opposed to opinions or

suggestions with the purpose of attempting to solve a problem. For example, the therapist responded to Participant 2's discussion about her being able to learn new skills in therapy but still working on her trust toward other individuals by agreeing with her and supporting her with the following statement (2b): "You know, we're never going to just stop learning and changing" (T82). Another example of a therapist opinion that was supportive of what the client discussed and not with the purpose of problem-solving, includes how the therapist responded to Participant 1's statement that he needed to take better care of himself or else he would not be able help others, including his family or girlfriend (1a): "And if you're so caught up in your own turmoil, your own pain, that you're not dealing with, you don't have room for other people, and for helping others" (T162).

A second subcategory of Recommendation #1 "*Encouraging*," (in which pre-existing codes *minimal encouraging* [FL1] and *direct encouraging* [FL2] fell under), was identified, including (a) empathic encouraging, (b) encouraging progress, and (c) encouraging choice. Specifically, 10 responses were *empathic encouraging* responses in which the therapist responded to the client's discussion of trauma with short empathic statements such as "wow," or "oh my," as well as longer statements expressing empathy such as in the following example of how the therapist responded when Participant 4 stated that she felt mostly positive about her upcoming surgery, but still somewhat afraid of burdening others based on her previous stroke diagnosis (4a):

- (4a) T31: [Therapist nodding] Understandably.
- T32: I can understand your fears and concerns.

Four encouraging responses were characterized as *encouraging progress* in which the therapist's response was used to support the client by using encouragement such as stating "I'm

so proud of you.” The following therapist response is another example in which the client (Participant 2) and therapist had been discussing how throughout treatment the client had learned to be more trusting toward people including the therapist as well as more open to new experiences:

(2a) T263: That’s, that’s so good to hear. Um, you know, we’re just out of time but you know I just want to say I know it’s really hard for you to talk about those things today and I’m really glad that you did and I’m really proud of you for saying them.

Such responses about treatment progress appeared to encourage clients to continue their discussions of trauma in session with the therapist.

Another type of encouraging response (4 responses) was *encouraging choice*. Specifically, this occurred 4 times with Participant 3 in which the therapist encouraged the client in making the right personal choice and decision-making process when deciding whether or not to remain living in the United States or move back to Turkey. These *encouraging* codes, in addition to the pre-existing *minimal encouraging* (FL1) and *direct encouraging* (FL2), encouraged the client to continue his or her discussion of trauma.

One new category that was derived using NOS responses that do not fit within Recommendations 1-4 included *engaging through opinion*, which does not appear to be conducive to the PTG process. These responses included (a) direct statements of instruction (3 responses) in response to the client asking a question (as opposed to giving the client a *choice* as to what he or she thinks he/she should do),

(3a) C53: [Client nods] Mm-hmm Okay. Well right now it would be interesting for me to write because you wouldn’t be able to read what I was writing but that may not be what you want. Do you want me to be able to read what I am writing?

T53: No.

C54: No?

(b) opinions about medical issues (2 responses),

- (1b) C53: And then these two are on these outsides. And then like through my hand right here. And I don't know if it's whether my hands are cramping up.
- T54: It can be associated with carpal tunnel too.

(c) therapist disclosures that were supportive in nature (5 responses; e.g. "I think that's a great idea"; as opposed to therapist self disclosures involving personal information; [2b] T97: Well I mean, I have to say I'm very excited to hear you say that."), and (d) opinions in which the therapist tried to convince the client of an opinion,

- (2a) C181: I might not be a really good person cause I got my attitude, I guess from them, I don't know, I got my attitude, but I'm not like thinking what they do. They think that, you know.
- T182: But do you think that having an attitude makes you not a good person? Cause what you're saying to me right now, you, you're a very good person. You have very, what you're saying to me is like very strong moral beliefs about not hurting other people, caring for them (LGb, FL4cF-C, NOS)
- C251: You know its kinda hard to hear because if you're a good person why do people do so many bad things back to you, you know, without you doing anything wrong to them.
- T252: I know. But what I'm trying to tell you though is that you're right, of course think about that, if you're a good person why would somebody do bad things to you. But C, what I'm trying to say is that not everybody can still get through all those things they way you got through them (LGb, NOS).
- C252: Yeah.

- T253: That's what's so amazing and great about you and what you should feel so, that's why it says about you, that you're a good person. And you got through these things and you, you have maintained these beliefs about yourself that I am different than them, that is so hard to do and you've done it. That's something, that's something that you should be so proud of yourself for (LGb, NOS).
- C253: I guess.

All of the responses within this new category illustrated therapist personal beliefs or I statements made for the purpose of engaging the client in discussion, but not necessarily *listening* or *trying to problem-solve*. For example, *opinions to convince* (4 responses) occurred in which the therapist for Participant 2 tried to support the client's actions and progress by attempting to convince her that she was a good person. This kind of response could not be coded as a *reflecting fact or emotion* (FL3a/FL3b) or *reframing what the client stated in a positive way* (LGb) because the client was repeatedly resistant to accepting the therapist's response that the client was a "good person." It is also different from *encouraging progress* because it concerns the therapist's opinion that the client is a good person, as opposed to information based on the client's actions or progress in treatment. This particular example resulted in the four statements in which the therapist tried to convince the client otherwise, possibly in an attempt to show her the "evidence" in a CBT intervention. It also may not have been culturally incongruent with the client's values to accept positive feedback or "compliments" about herself from another person. Thus, this new category represented statements that did not fit well into the coding system the researcher developed from Calhoun and Tedeschi's (1999) recommended counseling strategies.

Chapter 4. Discussion

This study examined if and how trainee therapists labeled clients' statements about trauma as struggles and opportunities for growth. The study aimed to bridge a gap related to how therapists may promote the process of growth following trauma in psychotherapy, in addition to exploring and potentially enhancing the applicability of the recommended counseling strategies in Calhoun and Tedeschi's (1999) clinician's guide. This chapter discusses this study's findings related to each of the four recommended PTG counseling strategies as related to relevant literature and PTG, as well as potential new subcategories of Calhoun and Tedeschi's recommendations delineated using NOS responses. A potential new category of therapist response was also found when examining therapist responses that the coders thought to be relevant but inconsistent with Calhoun and Tedeschi's recommendations (NOS responses). This chapter concludes with the study's limitations, contributions and directions for future research.

Findings for Recommendation #1: Focusing on Listening Without Trying to Solve

Across the 5 participants examined, the therapists in this study most commonly responded to participants' discussions of trauma using responses consistent with Calhoun and Tedeschi's (1999) Recommendation #1 *Focus on Listening Without Trying to Solve*. The codes created for this study were operationally defined using Rautalinko and Lisper's (2004) categories of reflective listening (RL) derived from theory and prior research (e.g., Lindh & Lisper, 1990; Hill, 1992; Rogers, 1961). Thus, the data suggests that therapists were either most well trained in and/or comfortable engaging in the psychotherapeutic process using components of RL, such as *minimal encouraging* and focusing on descriptive and evaluative content by *questioning* about and *reflecting facts* and *emotions*.

Specifically, the most frequently used response was *minimal encouraging* ($M = 86.9$, $SD = 69.7$), such as “Mm hmm,” “Right,” and nodding, which occurred throughout the sessions. Fitzgerald and Leudar (2010) suggested that these responses or *continuers* such as “Mm hmm” and “Right” are semantically empty responses that are therapeutically important in allowing the client to tell his or her story while the therapist listens. In their research, Fitzgerald and Leudar noted that these kind of responses are used to support the client as he or she tells his or her story, to claim understanding of what the client has said, to fill pauses ensuring the smooth flow of conversation, to mark the client’s intention to go on and at times to steer, nudge and maybe direct the client in a particular direction, such as to speak more about a particular topic in a particular way. The therapists in this study appeared to use continuer responses/*minimal encouraging* responses in all of the ways Fitzgerald and Leudar suggested, including directing the clients to speak more about their experiences of trauma. Thus, this kind of response represented a way in which the trainee therapists listened and related to the clients’ discussions of trauma. Although these responses may not have appeared to be as direct in reflecting or rephrasing growth statements made by the clients such as other response codes, the therapists did facilitate the client’s discussions by encouraging the continuation of their discussions using these *minimal encouraging* or continuer responses without focusing on problem-solving.

In addition to *minimal encouraging* responses, the therapists responded to clients’ descriptions and evaluative content in their discussions of trauma most using *closed-ended questions about factual* information ($M = 20.8$, $SD = 16.1$) and by *reflecting factual* information ($M = 20.6$, $SD = 15.7$), in both *early* and *later* sessions. The emphasis on asking *questions about facts*, such as details of the client’s traumatic situation, thoughts, beliefs, attitudes, and the nature of familial and romantic relationships, may have occurred for several reasons. In addition to

learning the importance of reflective listening in multiple theories of psychotherapy such as motivational interviewing (MI), cognitive behavioral therapies including dialectical behavioral therapy, and mindfulness (Rautalinko et al. 2007), the therapists' graduate training program, from personal experience and according to competency benchmarks for understanding and measuring competence in professional psychology across training levels (Fouad et al., 2009), emphasizes learning foundational information-gathering skills to establish competency in assessment and diagnosis of problems, capabilities, and issues associated with clients, clinical interviewing, case formulation, diagnosis, conceptualization, recommendations, and communicating findings in intake reports and assessment reports (Fouad et al., 2009).

Although the trainee therapists in this study may have applied the same skills of information gathering early in their therapy training with their clients in session, they appear to have been less attuned to processing the clients' affective experiences. Therapists responded to *descriptions* of the clients' traumatic events and *evaluative* content such as thoughts, beliefs, and attitudes about the traumatic event, more so than *affective* content such as one's feelings and emotions. The opportunity for processing the clients' affective experiences may have been diminished because therapists in this study primarily used closed-ended questions, which can be leading and offer the client very little opportunity to offer information other than what is being directly asked (Miller & Rollnick, 2002). Additionally, using an abundance of questions may create an assumption that the therapist is in charge of what is discussed in session, and that the therapist will provide answers or a solution (Weiner & Bornstein, 2009). Though closed-ended questions can result in gathering important information, they can also shift the focus of the therapy away from processing and make it appear more like an interrogation (Weiner & Bornstein, 2009). Had the therapists in this study used more open-ended questions, they may

have been better able to elicit emotion, clarify meaning, and help the client develop insight and explore alternative conceptualizations (Padesky, 1993) in their discussions of their trauma experiences.

Trainee therapists may also find themselves initially in graduate training uncomfortable asking clients how they feel in session as they talk about their experiences of trauma, because of the therapists' capacity to tolerate and manage strong affect, and countertransference such as rescue fantasies, a strong need to not fail their clients, care and concern for their clients, and insecurity about their own professional competence as trainees (Neumann & Gamble, 1995). Zoellner and colleagues (2011) noted that therapists new to exposure treatment often have concerns that in asking someone to revisit the trauma memory, the client will become so distressed that he or she will not be able to tolerate the distress. The therapists in this study may not have been providing exposure treatment per se, but the treatment of trauma in psychotherapy nevertheless may have caused the same concerns.

Further, in a study examining vicarious trauma in trainee therapists, Adams and Riggs (2008) assert that therapists may display restrictive defenses such as minimization or avoidance of traumatic material as well as distancing from the client. It is possible that vicarious trauma may have contributed to the therapists avoiding discussion about the client's emotions, and focusing on factual information instead. Adams and Riggs (2008) noted that several studies using samples of therapists have found that a shorter length of time providing trauma treatment is associated with more difficulty related to trauma work, including increases in avoidance, dissociation, anxiety, shame, and a sense of incompetence, and if left unattended and unresolved, there is the risk that the therapist may become emotionally distant and unable to maintain a warm, empathic, and responsive stance to clients. Thus it may have been easier for some

therapists in this study to rely on asking factual questions, or remain quiet in an effort to listen while the client speaks, rather than interjecting and discussing the client's affect. Because there is a lack of research in this area, future study would be valuable and will be discussed later in the Discussion section.

In the present study, there appeared to be as many therapist *questions* about *factual* information as *reflections* about it. This finding suggests that on average, therapists were diligent about using their reflection skills when trying to gather information about the clients' traumatic events and subsequent discussion. When looking at individual participants however, *reflecting facts* were not always used in conjunction with *questioning on fact* responses; some therapists (Participants 1 and 4) asked more *questions* than reflected information, and others *reflected* more information as the client described it rather than asking questions (Participants 2 and 3).

Consistent with Roger's (1961) theory that *reflecting fact*, *reflecting emotion*, *questioning on fact*, and *questioning on emotion* comprise the core skills of RL because they involve exploring and understanding the sender's message (Rautelinko & Lisper, 2004), therapist responses *reflecting emotions* ($M = 6.44$, $SD = 4.6$) were the next most commonly coded, followed by *reflecting ambiguous facts/feelings* ($M = 3$, $SD = 4.6$). *Reflecting* the client's *emotions* occurred more frequently than asking about emotions, with about the same amount of *open-ended questions* about emotions ($M = 2.8$, $SD = 2.5$) as *closed-ended questions* ($M = 2.4$, $SD = 2$). However, when relating to the client's discussion of trauma by inquiring about factual information, therapists asked *closed-ended questions* more often than *open-ended* ones ($M = 6.8$, $SD = 6.1$). *Open-ended questions* are more in accordance with RL because they do not restrict

story telling (Rautalinko & Lisper, 2004). Overall, therapists exhibited infrequent use of *questions* and *reflections* about clients' *emotions*.

Therapists also tried to help their clients solve problems using *therapeutic interventions* ($M = 2.3, SD = 2.2$) in an effort to *try to problem-solve*. With the exception of Participants 4 and 5, therapists' use of interventions occurred more often in the *later* sessions, which may be attributed to the client learning more strategies in graduate training over time. Such interventions included providing psychoeducation, encouraging the client (Participant 1) to use mindfulness meditation to help cope with anxiety as well as write about feelings that cause anxiety, and encouraging the client (Participant 2) to maintain more frequent contact with her sister as a means to strengthen their relationship and increase support. Although not consistent with Calhoun and Tedeschi's (1999) recommended counseling strategies for facilitating PTG per se, these approaches are indicated in assessing and treating trauma (Briere & Scott, 2006; Calhoun & Tedeschi, 1999), which Calhoun and Tedeschi (2006) advocate as part of the trauma recovery and growth process.

Therapists for Participants 1, 3, and 4 engaged in some *opinion/advice-giving* responses as a means to *try to solve*, but to a much lesser degree than *intervention* problem solving responses. Trainee therapists are taught in graduate training to not give *personal opinion/advice*, which is consistent with Gordon (1970) emphasizing that RL involves the receiver not sending a message of his own, such as an evaluation, opinion, or advice (Rautalinko & Lisper, 2004). Thus, therapist behavior such as providing opinions and giving advice with the intention of *trying to solve* were initially connoted as behavior incongruent with Calhoun and Tedeschi's (1999) *Focusing on Listening* recommendation. However, further analysis of therapist responses that were categorized and analyzed as NOS responses may suggest otherwise (see NOS section).

The remaining infrequently coded responses including *nonverbal referents*, *ambiguous questioning*, and *ambiguous problem-solving responses* ($M = 0-1$). Although therapy literature recommends the use of *nonverbal referent* responses as a means to facilitate reflective listening (Rautalinko & Lisper, 2004) no nonverbal referent responses were used. For example, in both Participant 2's *early* and *later* sessions, the client persistently rubbed his back and talked about his back pain while discussing his brother's suicide. The therapist made reference to the client talking about his back pain and inquired about it, but did not address his nonverbal behavior of rubbing his back while talking about the traumatic situation involving his brother. From personal experience, techniques of attention to *nonverbal referents* did not occur until much later in these therapists' graduate training, which may account for why none of the therapists responded in this manner during their clients' discussions of trauma.

In summary, the therapists in this study most commonly responded to participants' discussions of trauma using responses consistent with Calhoun and Tedeschi's (1999) Recommendation #1 *Focus on Listening Without Trying to Solve*. *Minimal encouraging* responses were used most frequently. The therapists responded to clients' descriptions and evaluative content in their discussions of trauma most using *closed-ended questions about factual information* ($M = 20.8, SD = 16.1$) and by *reflecting factual information* ($M = 20.6, SD = 15.7$), in both *early* and *later* sessions. Overall, trainee therapists appeared to have been less attuned to processing the clients' affective experiences. Therapists also tried to help their clients solve problems using *therapeutic interventions* ($M = 2.3, SD = 2.2$) in an effort to *try to problem-solve*, more than using opinions or giving advice for that purpose. As discussed below (NOS section), therapists used opinions and advice for supportive reasons.

Findings for Recommendation #2: Label Growth When it is There

For the Recommendation #2 *Label Growth When it is There*, Calhoun and Tedeschi (1999) advised that the therapist should acknowledge and reinforce when clients make reasonable positive interpretations of growth coming from their struggles with trauma. As the client begins to articulate positive changes into the account of the event or in the narrative of his or her life, the therapist can label these changes that the client identifies as already present or reframe the way the individual views certain events (Calhoun & Tedeschi, 1999). Overall, the therapists in this study infrequently responded to their client's discussions of trauma by *reframing changes as positive* (LGb, $M = 3.4$, $SD = 5.2$) and *verbalizing them as positive when the client made reference to them* (LGa $M = 2.1$, $SD = 3.2$). This finding may illustrate that a positive psychology or strength-based approach to trauma (Seligman & Csikszentmihalyi, 2000; Sheldon & King, 2001) may be neglected in early graduate training, especially with the emphasis on looking for negative symptoms that is emphasized in clinical psychology (Seligman & Csikszentmihalyi, 2000), as well as the previously mentioned focus on establishing basic skills of reflective listening as well as information gathering.

However, it is promising that 2 of the 5 therapists did use a relatively high frequency of responses consistent with Recommendation #2 *Labeling Growth When it is There* by reframing and verbalizing positive changes. This may be accounted for by therapist personal style or training, as some therapists may have had different training experiences than others. It could also be that these therapists became more attuned and better trained during the duration of treatment, or felt comfortable making strength-based reflections and verbalizations, because the majority of responses took place in *later* sessions.

Regarding the content of the therapists' positive verbalizations, themes found included coping strategies for Participants 1 and 4, trust, assertion, and protection in Participant 2, and self-exploration and decision-making for Participant 3. These themes coincide with some central treatment principles of trauma therapy (Briere & Scott, 2006). Briere and Scott suggest treatment principles to help clients recover from trauma, including providing and ensuring safety, stability, life stability, emotional stability, a positive and consistent therapeutic relationship, affect regulation, attention to memory intensity, and addressing cognitive schemas. Interventions used to facilitate this recovery include psychoeducation, distress reduction and affect regulation training, cognitive interventions, emotional processing, and increasing identity and relational functioning (Briere & Scott, 2006).

The therapist positive verbalization content theme that focused on clients' coping strategies for clients 1 and 4 was consistent with the treatment principle of promoting affect regulation, or an individual's relative capacity to tolerate and internally reduce painful internal emotional states (Briere & Scott, 2006). The therapists' positive verbalizations related to encouraging the clients to use coping strategies such as self-care and writing or drinking tea as a means to cope with anxiety or depression, instead of using drugs or compulsively scratching.

The themes of trust, assertion, and protection found in Participant 2's narrative were consistent with Briere and Scott's (2008) treatment principles of providing safety, emotional processing, a positive and consistent therapeutic relationship, and stability by increasing identity and relational functioning. The client's concerns about protecting herself and her sisters from their mother may signify the client processing her fears and hypervigilance that had resulted from the trauma she experienced. In this situation, the therapist's positive verbalization of the client's wish to protect her sisters appeared consistent with treatment recovery principles of

promoting affect and stability, in addition to her own feelings of safety. The positive verbalization about the client's increasing ability to trust others seemed consistent with her recovery of trauma as it can reflect or lead to an increase in her own sense of safety, identity and relational functioning with others.

The themes of self-exploration and decision-making that emerged from client 3 is also important to the recovery and growth after trauma, as illustrated by treatment principles of addressing cognitive schemas and promoting stability by increasing one's sense of identity (Briere & Scott, 2006). Positive verbalizations about the client's self-exploration and decision making process about his own values and whether or not he wanted to continue living in the United States were important to his recovery from acculturation trauma. The process and experience of migration has been connected to significant adjustment stressors impacting immigrants' mental health (Foster, 2001), including both *immigration stress*, defined as the psychological state resulting from variables that are inherent in any immigration experience, including loss of family, community, and familiar social networks, a reduction in job and/or socioeconomic status, lack of fluency in the host language, and actual or perceived discrimination (Foster, 2001; Greenman & Xie, 2008; Schwartz et al., 2010) and *immigration trauma* which is characterized by specific stressors related to immigration and their cumulative effects that precipitate symptoms of PTSD and clinical levels of anxiety and depression (Foster, 2001). These exploration and decision-making processes were consistent with the client's increasing his sense of identity and validation by the therapist. Addressing the client's cognitive schemas was also illustrated in the therapist facilitating the client's exploration of his thoughts, concerns, and decision making.

Findings for Recommendation #3: Events That Are Too Horrible

Only one therapist used a response consistent with *sharing with the client that other individuals have stated that have changed in some positive ways as they coped with their trauma* (EHa, $M = 0.1$, $SD = 0.3$). This one response occurred during Participant 5's discussion with his therapist about the sudden death of his friend, in which the therapist described that this kind of trauma has caused others to "wake up" in a sense and think about life differently. This response was used in conjunction with reframing responses as positive, which may suggest that therapist responses indicative of sharing that others have changed in positive ways coping with their trauma follow or are more likely to occur when the therapist is already positively reframing what the client states. The client may also be more open to this therapist suggestion if he or she is already responding to the positive reframes; however, there is no current research to support these ideas. Further, because only one response of a total of 1,350 talk turns evidenced this kind of response, this finding may not be generalizable. The infrequency of its use does suggest that training in this area of therapeutic intervention is limited, and that trainee therapists may benefit from learning strength-based interventions such as Calhoun and Tedeschi's (1999) counseling strategies to promote PTG with their clients.

Findings for Recommendation #4: Choosing the Right Words

One therapist used one of each response in this therapist response category. The therapist chose to *label or identify client statements reflecting PTG with words that reflected the individual's struggle to survive and come to terms with the event, as opposed to the event itself* (CWb) when the client discussed her fear of acting violently toward someone because of the violence her mother inflicted on her. Her "attitude" that the client refers to her anger and language she would use toward her mother and aunt when they were physically and emotionally

abusive toward the client. Though it was difficult for the client to receive the therapist's positive reframe, she still acknowledged that she would never behave like her mother and aunt, and would never treat children or adults like how they treated her.

In Participant 2's *later* session, the therapist *reinforced the positive interpretations of growth or positive changes coming from the struggle with trauma when the client made them* (CWa) regarding the client changing and becoming less ambivalent about wanting to trust other individuals. This response occurred during the discussion in which the client and therapist talked about the client becoming more receptive to change, and continuing to learn through therapy how to learn to trust people outside of the therapy, such as new friends. Because the therapist responses in this coding category were infrequently used, much like Recommendation #3, this finding may suggest that trainee therapists would benefit from further training in choosing the right words to help clients describe their struggles with trauma.

Findings for NOS Responses

The most frequently used NOS responses consisted of the new subcategory of Recommendation #1 *Focus on Listening Without Trying to Solve*, titled *Supportive Personal Opinions*, in which the purpose was not to attempt to solve but to agree with or support the client, appeared to assist in continuing the client's discussions of trauma. This finding may suggest another way of listening to the client that Calhoun and Tedeschi (1999) neglected to include in their recommended counseling strategies for facilitating PTG. Though there are numerous definitions of therapist self- disclosure in the literature, (see Henretti & Levitt, 2012), Quillman (2012) notes that therapist self-disclosure, defined as the therapist's report of somatic and/or affective experience of here-and-now-interactions with the patient, rather than disclosure of the therapist's personal history or experiences outside the therapy hour, is a logical and

powerful technique used to deepen the patient's capacity for self-regulation. Specifically, Quillman asserts that self-disclosure can decrease patient anxiety about negative affect, help the patient to discover that negative affect is not only less dangerous than initially feared, but can lead to a greater sense of connection and safety, and increase the transformational power of positive affect for self-regulation. Similarly, client-centered therapists argue that self-disclosure can model openness, strength, vulnerability, and the sharing of intense feelings (Henretti & Levitt, 2012). In a qualitative study examining 13 long-term adult psychotherapy clients recruited from 21 clinical psychologists in the mid-Atlantic region (race/ethnicity unknown), Knox, Hess, Petersen, and Hill (1997) found that helpful therapist self-disclosures resulted in positive consequences that included an improved or more equalized therapeutic relationship, normalization, and reassurance.

Another use of therapist *Supportive Personal Opinion* responses may have been for the purpose of using cognitive restructuring with clients in their attempt to help their clients reconsider and view their thoughts, attitudes, and beliefs about themselves and their traumas in a different way. Providing support for this idea, Knox et al. (1997) also found that helpful therapist self-disclosures perceived by clients as intended to normalize or reassure them resulted in insight or a new perspective from which to make changes. Of note, the therapist response *supportive disclosure* within the new category *Engaging Through Opinions* delineated from NOS responses would also fall under this category of self-disclosure discussed in the literature. Because *Supportive Personal Opinions* were the most frequently used NOS responses (72 responses) among the trainee therapists, it is a noteworthy finding in this study and would be valuable to integrate with Calhoun and Tedeschi's (1999) recommendations for promoting PTG in psychotherapy.

The NOS responses *encouraging progress*, *encouraging choice*, *empathic encouraging* (all within the new subcategory of Recommendation #1 titled *Encouraging Responses*), as well *trying to convince* (within the new category *Engaging Through Opinion*) appear similar to how Briere and Scott (2006) described how therapists should encourage growth and recovery in trauma treatment, including acknowledging the courage associated with the client's participation in therapy and the strength that is required to confront painful memories rather than avoid them. *Labeling Growth When it is There* (LGb) codes were also used in conjunction with *trying to convince*, suggesting that the therapist may have been eager to convince the client (Participant 2) of the progress she had made in therapy since the client did not seem to completely accept it. This may not be a surprise however, because according to Briere and Scott the client may not completely believe the therapist's positive appraisal of him or her, however visible therapist respect assists greatly in establishing a therapeutic rapport, increasing the likelihood that the client will make him or herself psychologically available to the therapeutic process. This same therapist also used the responses *encouraging progress* and *supportive self-disclosure* in conjunction with *trying to convince* to try to convince the client of the reasons why she was a good person, and the client again had difficulty initially accepting the therapist's praise. Another explanation for this client's particular response is that individuals who have struggled with chronic trauma may see themselves as helpless and defective, and not want to accept or see themselves as lovable, valuable, and competent (Cook et al., 2005). While *encouraging progress*, *supportive self-disclosure*, and *trying to convince* are not part of Calhoun and Tedeschi's (1999) recommendations, they appeared helpful in assisting the client to acknowledge her own progress and growth later in the therapy session.

Finally, it is difficult to tell if responses such as *direct instruction opinion* and *medical opinions* within the new category *Engaging Through Opinions* were helpful to the clients, since these types of responses may be more closely related to advice/problem solving that is inconsistent with the listening process that Calhoun and Tedeschi (1999) describe. They were not coded as problem-solving codes because their intent appeared to be engaging with the client, and not problem-solving. In particular, they may be similar to psychoeducation or a directive component of trauma treatment therapy. Further exploration involving client reactions to therapist use of these responses in the listening process during trauma discussions may be of interest, given the potential for such responses to be consistent with other approaches to trauma treatment that have empirical support.

PTG and Other Growth Considerations

This section expands upon the previous discussion of the study therapists' use of Tedeschi and Calhoun's (1999) recommendations by turning the focus to the client-participants' struggle with trauma and potential types of growth they may have experienced, both consistent and inconsistent with Tedeschi and Calhoun's (1996) growth areas in their PTG theory. It concludes with examples of therapists' missed opportunities for facilitating growth with their clients, which has implications for future study.

The 5 therapists in the current study did not indicate or reframe their clients' experiences as a result of the *struggle* with traumas, the key component of Calhoun and Tedeschi's (1999) recommendations. However it appears they helped clients facilitate some growth nonetheless, possibly through their focus on listening and engaging with the client's discussions of trauma. It is also possible that some clients were struggling with their traumas, given their symptom presentations, even though the therapists did not label the process of struggle as potential for

growth. Similarly, the clients may have experienced aspects of PTG, but growth was not therapist-facilitated or otherwise captured in the coded sessions.

According to Sheikh (2008), a commonality across Tedeschi and Calhoun's (1996) areas of growth is that they each involve active engagement and openness to change. Thus potential growth among the 5 participants is next discussed in terms of openness to change and active engagement as well as the five growth dimensions *relating to others, new possibilities, personal strength, spiritual change, and appreciation of life* (Tedeschi & Calhoun, 1996). It is followed by a discussion of other factors that may have influenced the growth process including experiences from prior traumas, social support, cultural factors, and a discussion of missed opportunities for growth.

Active engagement and openness to change. All 5 participants experienced changes that evidenced active engagement and openness to change. In addition, among Tedeschi and Calhoun's (1996) three broad categories of growth (a) *changes in the perception of self*, (b) *changes in the experience of relationships with others*, and (c) *changes in philosophy of life* and their five growth dimensions delineated from these three broad categories, (a) *relating to others*, (b) *new possibilities*, (c) *personal strength*, (d) *spiritual change*, and (e) *appreciation of life*, two clients appeared to have experienced *personal strength* (Participants 2 and 3); one may have experienced *new possibilities* (Participant 3) another possibly *changed philosophy of life* (Participant 1), and one *changed sense of self* (Participant 4). Each participant's PTG related to these domains is discussed in this subsection.

In Participant 1's *early* session, he showed active engagement in his decision making of deciding to not return to his parent's hometown, and to continue focusing on his work and current life in California. In Participant 1's *later* session, he showed active engagement in his

decision to increase his self-care by making his needs a priority such as focusing on his work rather than taking care of his ex-girlfriend's emotional needs, which was done more than as discussed in the *early* session. Also Participant 1's experience or struggle with his brother's suicide, compounded by his recent apartment robbery, may reflect a one of the five dimensions of PTG, *changed philosophy of life*, in which a confrontation with death can lead to a greater appreciation of the value of everyday things (Tedeschi & Calhoun, 1996; Yalom, 1991).

Individuals can experience growth as a *changing in spiritual or religious beliefs* (another one of the five dimensions of growth), and a deepening of one's existential experience in a positive way (Calhoun & Tedeschi, 1999; Tedeschi & Calhoun, 2006). Participant 1 illustrated this possibility when in his trauma discussion about his thoughts of his brother's suicide he talked about his higher purpose, which is to help others deal with pain by exposing it in film. It is also possible that this belief may have already existed for the client, and his experience of his brother's death further reinforced it.

Participant 2 showed openness to change by trusting her therapist and showing a willingness to make friends and trust other individuals (though this may be accounted for by her trusting relationship with her therapist in which the client stated that she felt trust toward the therapist which made it easier for her to talk about difficult emotions and be open to trusting others and perhaps making friends, and not necessarily because of the struggle with trauma she experienced), as well as changes in perception of self such as not being a violent person like the individuals in her family. However, these changes in the client's openness to trust may or may not fit into one of the five dimensions of growth, Tedeschi and Calhoun's *relating to others*, which implies a greater sense of closeness with others following adversity, voicing more honesty about what they really think, feel, feel a greater ease in expressing themselves emotionally with

others, and increased empathy and compassion for other persons facing crises. On the one hand, Participant 2 voiced with her therapist what she really thought and felt about her abusive upbringing, as well as empathy and compassion for her sisters facing similar circumstances. However, this appears to be a product of the client disclosing her thoughts and feelings in therapy as well as sadness and guilt about her sisters, rather than voicing what she thinks to her sisters or friends; or voicing a greater sense of closeness with others. It seems that her therapist was facilitating changed self-perception by reframing and verbalizing Participant 2's positive changes. Yet, because it was difficult for Participant 2 to acknowledge and accept the therapist's positive reframes about the client being a good person and unlike her violent family members, perhaps more time in treatment would allow for the client to develop her narrative including growth over time.

Participant 3 showed active engagement in his decision-making process regarding living in the United States, attending school, and dating life, as related to others' expectations within his Turkish community, which his therapist reframed as positive. Participant 3's experiences of personal growth appear to be more focused on his decision-making skills, which were met with feeling stuck as well as frustration with his therapist not helping him through it, rather than fitting within the five dimensions of growth that Tedeschi and Calhoun (1996, 2004, 2006) suggest. Although his experiences may be most similar to *personal strength* and *new opportunities* because of his decision to focus on making his own choices as well as take advantage of opportunities that he has available in the United States to reach his career and family goals, his struggles were not reframed or talked about as being a result of his traumatic experiences with acculturation or his father's death. Exploring the client's struggles with acculturation and the potential for growth may have been valuable since studies show that

immigrants of many cultures have experienced PTG following acculturation (Weiss & Berger, 2010)

Participant 4 experienced openness to change with regard to her perspective of how her “pseudo son” was treating her, as well as feeling stronger after the medical traumas she had experienced (though the therapist did not touch on the latter, as will be discussed later). For example, the client became open to perceiving her pseudo son’s behavior of isolating in his room as a product of “teenage boy behavior” rather than taking it personally. This therapists’ (two) growthful responses to the client in her *later* session in which she *reframed the way the client viewed certain events* (LGB) related to the client’s change in thoughts about her feeling rejected by her friend’s son; however, this does not fit in with any of Tedeschi and Calhoun’s (1996, 2006) dimensions of growth.

Participant 4 also appears to have experienced one of five of Tedeschi and Calhoun’s (1996) dimensions of growth *changed sense of self*, which describes following a traumatic event or crisis, an individual’s successfully meeting numerous specific demands can greatly enhance one’s sense of personal strength and a strengthened sense of competence in meeting future life demands (Calhoun & Tedeschi, 1999). As part of *changed sense of self*, Participant 4 discussed feeling stronger by using the analogy that she feels like she is wearing armor after experiencing multiple health traumas including her stroke and multiple surgeries. Although the therapist did not reframe this client’s statement of growth or acknowledge its positive aspects, and instead continued the discussion with minimal encouraging responses, it does illustrate the opportunity for growth-related therapist responses. Numerous studies illustrate that growth and positive changes occur following a variety of medical illnesses, including stroke (Gangstad, Norman, & Barton 2009), acquired brain trauma (McGrath & Linley, 2006), heart disease (Sheikh, 2004),

breast cancer (Cordova et al., 2001, 2007), prostate cancer (Thornton & Perez, 2005), bone marrow transplantation (Widows, Jacobsen, Booth-Jones, & Fields, 2005), and many more. Further, similar to therapist response codes consisting of positive reframing used in this study to identify use of Calhoun and Tedeschi's (1999) strategies recommended to facilitate PTG, as well as Tedeschi and Calhoun's (1996, 2006) emphasis on the importance of cognitive restructuring, Gangstad et al. found that PTG in stroke patients correlated with positive cognitive restructuring, Thornton and Perez (2005) found that coping using positive reframing and social support were associated with higher levels of PTG one year post-surgery in prostate cancer survivors, and Widows et al. found that positive reinterpretation and problem-solving were associated with greater PTG in cancer patients' post-transplant period.

The therapist for Participant 5 stated that the client may feel "awakened" after his experience of his friend's death. Thus, the therapist facilitated the discussion using growthful responses. However, it was unclear if the client's feeling of being awakened to the vulnerability of life with the sudden death of his friend was the result of just having been shocked by the event or how he cognitively processed the traumatic experience. Cognitive processing in Tedeschi and Calhoun's (1996) model of PTG as well as according to principles of trauma treatment (Briere & Scott, 2006) is an important component involved in the recovery and growth process from trauma. It is unclear if Participant 5 experienced cognitive processing since there were no other available psychotherapy sessions to examine to observe if the client again referred to being "awakened" and expanded upon its meaning and impact, such as describing making long-term changes to his life resulting from this struggle with his friend's death.

Other growth-related factors. Other factors that may have influenced the growth process include experiences from prior traumas, social support, and one's culture and spirituality.

The participants' experiences of prior trauma may complicate the growth process because definitions of *trauma* encompass both (a) isolated incidents that tend to produce discrete conditioned behavioral and biological responses to reminders of trauma such as those captured in the PTSD diagnosis, as well as (b) broader ways in which the traumatic stress field has more recently defined as constituting trauma. These ways include the terms *complex trauma*, *developmental trauma disorder* (DTD; van der Kolk, 2005) to describe the experience of multiple, chronic, and prolonged, developmentally adverse traumatic events often of an interpersonal nature (van der Kolk, 2005), *disorders of extreme stress* (DESNOS; van der Kolk et al., 2005), which refer to a broad range of symptom clusters such as affect dysregulation, relational problems, cognitive distortions, dissociation, tension reduction behaviors, and somatization (Pelcovitz et al., 1997), and *complex PTSD* (CPTSD; Courtois, 2008) which includes an expanded understanding that extends to "other types of catastrophic, deleterious, and entrapping traumatization occurring in childhood and/or adulthood" (p. 86), including situations of acute and chronic illness, to a single catastrophic trauma. Thus it is difficult to know if growth occurred after one traumatic event, or following multiple traumas.

All of the participants in this study experienced multiple incidents of trauma, with acute event traumas compounded by prior chronic traumas. Yet, none of the PTG models, including Tedeschi and Calhoun's (1996, 2006), conceptualized how complex trauma, CPTSD, or DTD might impact the PTG process, especially as it relates to experiences of multiple, chronic traumas, as well as traumas during critical periods of brain development (Ford & Courtois, 2009). Instead, theories of PTG have addressed mostly single traumatic events that are synonymous with those associated with a diagnosis of PTSD. Thus, it is difficult to know to what extent Tedeschi and Calhoun's markers of growth apply to the 5 participants' trauma

experiences since their difficulties did not exist solely after a particular event, but rather after multiple events. Be that as it may, indicators of growth were identified in the psychotherapy sessions, even if they did not fit into all of Tedeschi and Calhoun's (1996) three overarching categories or five dimension of growth or their Recommendations #2-4.

Regarding social support, 3 out of the 5 participants referenced a great deal of support from others, including Participant 2 who had support from her husband, and Participant 4 who had support from her friend/roommate. Participant 3 greatly valued the emotional support of his mother, though she had been living in another country. Participant 1 expressed minimal support from his previous-live in girlfriend and Participant 5 did not talk about supportive others. Calhoun and Tedeschi's (2006) model suggests that the importance of social relationships to PTG lies in individuals' abilities to promote rumination and subsequently the revision of schemas. In other words, supportive others may communicate positive messages about how an individual is handling his or her experience of crisis or trauma, and then the person internalizes or uses this to change his or her perspective (McMillen, 2004).

McMillen (2004) suggested that there may be other ways in which social support may directly facilitate the development of positive changes. For example, in addition to fostering views of personal strength, receiving positive messages through social support may remind individuals of the importance of family and friends, and of the goodness of others (McMillen, 2004). Further, a compassionate response may be modeled by supportive others, allowing the individual experiencing adversity or trauma to call on these skills if needed in the future (McMillen, 2004). For example, Participant 2 shared that her husband was extremely supportive of her attending therapy and helped her to feel more calm during times she had difficulty coping with her emotions, especially when feeling suicidal or angry toward family. In another example,

although Participant 3's mother lived in another country and therefore was not in close physical proximity for support, Participant 3 expressed that his mother acknowledging that she would rather he live in the United States and be happy than be unhappy and live in his home country greatly relieved his feeling of guilt for making the decision to remain in the United States to pursue his own goals. Because the cognitive focus of Tedeschi and Calhoun's model overlooks the possible contributions of these larger systems of support to fostering PTG, supportive others may have influenced the growth process in ways that Calhoun and Tedeschi's (1999, 2006; Tedeschi & Calhoun, 1996) growth dimensions and recommendations could not capture (McMillen, 2004); and as such, were not included in this study's coding system.

Because the participants in this study were of different cultural backgrounds, cross-cultural differences in the experience and expression of growth may have occurred (Abraido-Lanza et al., 1998; Ho, Chan, & Ho, 2004; Taku, Calhoun, Tedeschi, Gil-Rivas, Kilmer, & Cann, 2007; Weiss & Berger, 2006a, 2006b), as well as due to cultural differences relative to individualism versus collectivism (Weiss & Berger, 2006). For example, Participants 2, 3, and 5 identified as from a collectivistic cultural background while Participants 1 and 4 identified as from an individualistic cultural background, possibly resulting in of growth among individualistic participants such as becoming more self-reliant or assertive (Participant 4) and recognizing and relying more social support among collectivistic clients (Participants 2 and 3).

Not only do Calhoun and Tedeschi (1999) emphasize the importance of spiritual and existential beliefs in helping clients with crisis, empirical studies have demonstrated that one's spirituality and culture can be significantly tied to PTG (see Pargament, Desai, & McConnell, 2006) because spirituality can play a role in the meaning-making process, provide support and empowerment during stressful times, and may foster life-changing transformation of goals and

priorities (Pargament et al., 2006). As discussed further below, one of the participants in this study (Participant 1) discussed changes in spiritual or existential beliefs with his therapist. The therapist responded minimally to it. And when another client (Participant 5) asked about the religious connection of the community counseling clinic's program, the therapist changed the subject.

Missed opportunities for growth responses. During the analysis of the results, the researchers found examples in the transcripts of therapists not reinforcing or reframing potentially growthful statements made by the clients. Participant 1 illustrated this possibility when in his trauma discussion about his thoughts of his brother's suicide he talked about his higher purpose, which is to help others deal with pain by exposing it in film. Unfortunately the therapist did not reinforce the client's existential/higher purpose views; instead she responded only with minimal encouragements.

C47: Yeah, I would do that. I would, I'm just telling you. Like whatever happens is- like if I'm ever dead because somebody thinks I killed myself you need to find someone that did it. It's seriously like that. I have a higher purpose for being here on earth. [C grabs his upper back with his right hand]

T48: Mm-hmm

C48: And it's not necessarily making films or whatever. It's the journey that I'm a part of other people's energy. And I've been trying to change like you know, I've been trying to be...

T49: Mm-hmm [T nods]

C49: ...a better person. And uh, sorry my back's really hurting. Um, and so I really, there's things that I can do in my life, that can expose other people's pain, and let them like almost get rid of it. Like, like, it's like if you expose a wound, if you make a film, or have a project, that's that touches people and moves people to think about things or like change their way of thought. It's really a powerful art like uh, tool, like it's a powerful thing to have as an artist.

T50: Mm-hmm [T nods]

C50: Like it's hard to draw a painting that can do what I can do on film. It's hard to take a single picture and be like, hey this picture is going to change the way people think about this topic.

T51: Mm-hmm [T nods]

It is also possible that this belief may have already existed for the client, and his experience of his brother's death further reinforced it. Another example of a missed opportunity to facilitate PTG in Participant 1's *early* session is illustrated:

T79: Because you have this pattern of not really taking care of yourself, but worrying about the people around you. So I want to know what's going on with you? You told me what's going on with your dad, and your step-mom, and your sister, what about for you?

C79: With me, um, through all of this, I've like gained a lot of perspective of how important things are you know.

T80: Mm-hmm [T nods]

C80: And like it makes the stuff with (C's girlfriend), like we don't, haven't argued since. Like she's been really good, like she's gotten a lot perspective from it. And like, like just remembering why – I guess I don't know she almost just snapped out of it. She was making so much of it. It made her crazy.

T81: Mm-hmm [T nods]

In this example, the client alluded to his perspective changing as well as his girlfriend's perspective changing following his brother's suicide and apartment robbery, which is consistent with how Calhoun and Tedeschi describe a component of PTG in which individuals gain a *new philosophy in life*, such as a shift in life priorities (Calhoun & Tedeschi, 1999). However, the therapist did not attend to it and continued to listen using *minimal encouragement* responses rather than taking the client's responses instead of reinforcing potential growth.

Another example was located in Participant 4's early session, in which the client described that she has a lot of family support. It may have been helpful in the client's recovery and growth from her medical traumas for the therapist to reinforce the strength of the client having so much support. Instead, the therapist followed with minimal encouraging responses:

C28: And do I want that environment to be in America? Do I want it to be in England? I really don't want to move back to England but I've got endless amount of support there.

T28: [nodding] Right

C29: And I have endless amount of support here.

T29: Uh-huh

Similarly, in 4b:

T2: Oh good, okay thank you. So how are you feeling?

C3: I think probably over-whelmed is a good- every time anyone asks me I'm like I'm fine, I'm fine, I'm fine so it doesn't really seem to be an alternative to being fine but I think I am overwhelmed with being fine.

T3: Yeah.

C4: Um, [client shrugs] I don't know I mean these things keep coming at me.

T4: Right.

C5 : And I was talking to a friend of mine in England yesterday and I said I feel like I have a coat of armor on and it keeps getting things thrown at it and its got all these little chinks in it [client laughs].

T5: Uh-huh. How is your sight now?

In this example it may have been helpful for the therapist to explore the client's analogy of feeling like she is wearing a coat of armor that keeps getting things thrown at it, because it could have reframed or reinforced the client's view that she has strength and keeps persevering with "all of the things coming at her," especially due to her struggle with her medical traumas. This kind of client response is indicative of growth of new personal strength following the struggle with trauma (Tedeschi & Calhoun, 1996).

Limitations

There were several limitations to conducting this study, including those connected to its methodology and content analysis approach. These involved inter-rater biases, observing PTG using a specific theory, defining clients' subjective experience of trauma, and using a small sample of trainee therapists.

First, in using this particular methodology, it was difficult to avoid potential group bias in the coding process, which may have resulted in consensual observer drift (Harris & Lahey, 1982). In other words, it is possible that the coders modified their recordings to some extent to agree with those of another coder with whom they previously had the opportunity to compare ratings (Harris & Lahey, 1982). To increase the reliability of this study as it relates to the

coding process such as controlling for coder fatigue and subsequent coder drift, several steps were taken. For example, weekly and biweekly conference calls focusing on inter-rater discussions of the coded responses did not exceed two-hours, and multiple in depth inter-rater discussions of the codes for each transcript talk turn took place following the independent coding. During the group discussions when the coders were required to make judgment calls, as in cases of inter-rater disagreement, the rationale for each judgment was documented in an audit trail using an electronically-shared document so that the auditor could obtain an understanding of the coder judgment process (Orwin, 1994), and provide feedback to the coders when necessary. The coders discussed and integrated the auditor's feedback, which either helped reach a consensus of final codes or facilitated additional discussion of codes and feedback from the auditor until reaching final coding decisions for data analysis. Additionally, each coder preserved a copy of his or her initial independently-derived codes, a self-reflective journal in which to record biases during the coding process, in addition to the codes discussed upon group consensus, to help maintain awareness through self-monitoring of biases and help prevent their potential influences during the coding process.

Though steps were taken to help increase the reliability of the coding process and the subsequent results, it is possible that the study's validity may have been impacted by the three coders who participated in this study. For example, a limitation of the study may have been that the coders were directly affiliated with the research project, causing further potential for bias in the coding process. Using coders who were not associated with the research project, as well as a greater number of coders, may have limited the potential for bias that may occur due to coders directly related with the research looking for particular therapist responses that would either confirm or disconfirm the researchers' hypotheses.

Also, by coding the same participant sessions for their individual research studies, the coders' perspectives of the discussions of trauma may have been possibly altered over time and in using different ways to examine the data. To control for this however, a broad, open coding system derived by another coder to look for general therapist responses during discussions of trauma was used first to examine the data, followed by more specific coding systems (including the one used in this study) derived from prior theory related to strength-based approaches. This way, coders first viewed and approached the data using broadly defined categories of therapist responses to clients' discussions of trauma, followed by using more specific coding systems to examine them.

Using coders of different cultural/ethnic backgrounds as the participants may have also confounded the study. The coders in this study may have been less sensitive in identifying therapist responses consistent or inconsistent with PTG as it relates to the participant's culture/ethnicity because the coders and auditor in this study were primarily of a different cultural and ethnic background than the participants. Thus future study using coder, auditors, and participants from similar backgrounds may be valuable in researching diverse client populations.

Second, using theory to guide the content analysis has some inherent limitations in that researchers approached the data with an informed but strong bias, as consistent with the use of this approach (Hsieh & Shannon, 2005). In other words, an overemphasis on theory can blind researchers to contextual aspects of the phenomenon making it more difficult to remain neutral or objective when examining the data (Lincoln & Guba, 1985). Though using theory and prior research offers focus and support in creating of a coding system, researcher bias may still have affected how data was operationally defined and categorized in domains. For example, the

author identified her own bias toward identifying opportunities for growth in addition to therapist responses as reflecting positive changes rather than neutral changes. Hence, researchers might have been more likely to find evidence that was supportive rather than non-supportive of Calhoun and Tedeschi's (1999) recommendations for facilitating PTG in psychotherapy. To adjust for biased results, having an auditor review and examine the operational definitions as well as the coder's codes of Calhoun and Tedeschi's recommendations served to increase the accuracy of predetermined categories and control for coder drift.

Additionally, coding therapist responses consistent with Recommendation #1 *Focus on Listening Without Trying to Solve*, which was derived using prior research in reflective listening (Rautalinko & Lisper, 2004), limited the author's codes to examining therapist questioning and reflecting *factual content* and *emotional content*. It may have been more beneficial to create categories to distinguish *factual content* such as "situational details" related to the trauma discussion from "cognitive processes" of the client, including thoughts, beliefs, worries, and decision making. This way the author could have distinguished and examined the use and frequency of therapist responses focusing on situational details versus the clients' cognitive processes, rather than including them together in one category of *factual content*. Then, therapist responses focusing on engaging the client in cognitive processing could have been further analyzed for their relation to facilitating PTG.

Another limitation could be that other ways of measuring PTG were not used, including Calhoun and Tedeschi (1999) recommendation *Notice growth as the client approaches it*, which describes the process of the therapist bringing growth into focus as an internal process of the therapist looking beyond the meaning of words to see the larger pattern of struggle. Because this recommendation is considered to be an internal process of the therapist, it was not observable for

the researchers to code. A study utilizing interviews or questionnaires to learn more about the therapist's internal process while working with clients who have experienced trauma may shed light on this aspect of possibly facilitating PTG with clients in psychotherapy. Other ways to measure PTG that were not utilized in this particular study also include quantitative measures (e.g., PTGI, SRGS) as well as qualitative designs consisting of in depth interviews of clients to gain a better perspective of their possible growth following trauma.

A third limitation of this study was the difficulty in defining and examining what constituted *trauma*. Often the term trauma is used to refer to exposure to negative events that produce distress, as well as psychological reactions or the subjective experience of the traumatic event itself (Briere & Scott, 2006). It is also challenging to identify another individual's subjective experience of trauma. This study attempted to gather information about subjective experiences through examining discussions of trauma in videotaped psychotherapy sessions that contained descriptions of the traumatic event, evaluative content such as thoughts, beliefs, and attitudes about the traumatic event, and affective content such as one's feelings and emotions about the traumatic event (Chelune, 1979; Cozby, 1973; Jourard, 1971; Omarzu, 2000; Pennebaker et al., 2001). However, clients may not have verbalized their thoughts or feelings about their traumas. Individuals may have avoided talking about their traumas, and/or avoided experiencing emotions associated with their traumas. Avoidance symptoms of trauma may be cognitive (avoiding thoughts, feelings, memories), behavioral (avoiding people or places that might trigger memories), dissociative (amnesia of the stressor), and partially physiological, such as emotional numbing (Briere & Scott, 2006). As such, the coders may not have recognized client discussions of events or experiences as subjectively traumatic, and the study did not examine nonverbal behaviors.

Observing discussions of trauma related to clients' cognitions and emotions as well as potential growth was also complicated by the fact that the majority of participants in this study presented with diagnoses comorbid with trauma (i.e., Major Depressive Disorder, Borderline Personality Disorder, Social Phobia) rather than solely PTSD or isolated traumas. This comorbidity may have resulted in clients presenting in different ways of relating to their therapists, especially with regard to trust and avoidance. For example, Participant 5 may have been resistant to talking about his thoughts or feelings because of his social phobia rather than avoidance of painful affect related to the trauma (or perhaps a combination of both). One way to possibly eliminate these confounds and isolate use of therapist responses with clients with specific disorders, would be to examine homogenous samples of clients with specific DSM-IV diagnoses (e.g. a Major Depression-Only group). However, because a number of different symptoms and disorders are associated with exposure to traumatic events (Briere & Scott, 2006), the heterogeneous sample of participants used in this study seemed appropriate for the purpose an initial study of therapist responses to clients' discussions of trauma as well as potential PTG.

Further, though Calhoun and Tedeschi (1999, 2006) provide some general ways of approaching work with individuals who have experienced traumatic stress, it is unlikely that every aspect of the PTG process was captured in the codes derived using their theory of counseling strategies. For example, the PTG models discussed in the literature review are adult-focused models. Considering the impact that trauma has on the brain and personality development early in life, such as DTD, a more comprehensive model of how children may experience growth and the PTG process might have better influenced or defended against the effects of future traumas. However, the main research question was to explore this process to

potentially add meaningful information to the theory of PTG, as data that did not fit with Calhoun and Tedeschi's recommendations was coded and analyzed as well (NOS).

Finally, the small sample size may limit generalizability from a quantitative standpoint; however being a qualitative study, the transferability, or the generalizability of inquiry, of the findings should be sufficient for the particular population being studied considering the detailed account of the data collection and analysis process (Creswell, 1998). Also no information was available on the years of training completed by the small sample of trainee therapists examined in this study. Yet, it can be assumed that they were not yet competent in more advanced treatment modalities used by seasoned therapists in specialized training; therefore, they may be expected to be less equipped to treat individuals experiencing repeated and chronic trauma and to rely on informed supervision. It is also unknown whether or not the therapist in this study received prior training in using PTG counseling strategies, so it might have been difficult or unfair to expect them to utilize growth/strength related recommendations without prior exposure. Because the therapists in this study operated from a university-based community counseling clinic, they used various therapeutic techniques acquired in their graduate training curriculum to help their clients discuss and process experiences of trauma, including elements of cognitive behavior therapy, dialectical behavior therapy, psychodynamic, and supportive psychotherapy. Though these approaches may seem inconsistent with using one type of specific trauma treatment such as CBT for PTSD (see Briere & Scott, 2006) that a more seasoned therapist may use, Courtois (2008) suggests that many treatment approaches and strategies from a variety of theoretical perspectives apply to the treatment of individuals with complex trauma, such as how the 5 participants in this study were treated. Because treatment is multimodal and trans-theoretical to encompass the multiplicity of problems and issues presented by these clients

(Courtois, 2008), trainee therapists may have been provided with appropriate skills to treat these more complex cases despite being early in their training. Regardless, an examination of the therapists' clinical competence was beyond the scope of this dissertation.

Future Directions for Research

Recent emerging literature suggests that trauma has the potential to be a deeply transformative experience in a positive and valuable way for some individuals (Briere & Scott, 2006; Calhoun & Tedeschi, 2006; Sheikh, 2008). Therapists are encouraged to play a role in assisting clients in the PTG process, and Calhoun and Tedeschi's (1999) recommendations are one way that therapists may try to achieve this goal. Yet, the results in this study indicated an overuse by all trainee therapists of Calhoun and Tedeschi's (1999) Recommendation #1 *Focus on Listening Without Trying to Solve*, and the other three recommended counseling strategies intended to promote processing the client's struggles with their traumas as opportunities for growth were rarely used. Although therapists in this sample may not have used Calhoun and Tedeschi's (1999) recommendations, some growth was observed. Thus, future research is needed to determine whether other samples of therapists follow the recommendations or otherwise assist their clients in experiencing PTG.

One way to achieve this broad research goal is to compare how a group of therapists working from current treatment models/treatment as usual versus a group who have received specific training in PTG and other trauma-specific treatments respond to clients' discussion of trauma in psychotherapy. The PTG trained group could receive education about possible dimensions of growth following trauma and specific counseling strategies to promote PTG including role-plays and skills practice with the aid of a supervisor, and/or additional emphasis on PTG counseling strategies in intervention-based graduate coursework. Or they could be

trained with a manual developed for the study, as described further below. Then, using a similar methodology to the current study, researchers could examine if therapists in the 2 groups showed any difference in use of the counseling strategies that help facilitate PTG in session, by measuring the frequency of therapist responses consistent with Calhoun and Tedeschi's (1999) recommendations, with attention to the frequency of responses consistent with Recommendations #2-4 that were minimally used by therapists in the current study.

Although the therapist-participants in this study were early trainees and thus operated using relatively atheoretical orientations, future studies may want to examine how more seasoned therapists of different orientations, such as CBT and Psychodynamic psychotherapy, may use PTG counseling strategies with their clients in psychotherapy. Research of this nature may inform how different treatment modalities do or should incorporate strength-based approaches such as promoting PTG.

A similar study may also benefit from using different coders, specifically coders of similar cultural/ethnic background as the participants, and coders not directly affiliated with the research project or its data analysis. The purpose of incorporating additional coders, especially those not affiliated with the research project, would be to help reduce or eliminate the influence of prior knowledge of PTG theory as well as personal biases that may guide one's "looking" for desired therapists responses supportive of the author's hypotheses. For example in the current study, the author shared her bias of wanting to find strength-based or growth-related therapist responses within the client-therapist discussions of trauma. It may also be valuable to enlist coders of similar cultural/ethnic backgrounds as the participants of the study to provide the additional lens of identifying therapist responses or client-therapist interactions conducive or not conducive to encouraging client strengths or PTG that may be missed by the coding system derived from

Calhoun and Tedeschi's (1999) PTG counseling strategies. This way, the participants' culture may be better accounted for when analyzing the data in determining themes of positive verbalizations, dimensions of possible growth, as well as ways to better facilitate the PTG process among a culturally diverse population.

Modifying this study's coding system in addition to more thoroughly practicing using the developed codes on individuals in a sample other than the target population may be beneficial. For example, the coding system derived using Calhoun and Tedeschi's (1999) recommended counseling strategies could be modified to include categories of factual content that distinguish between *situational details* related to the trauma as well as *cognitive processes* of the clients, including the clients' evaluative content such as thoughts, beliefs, attitudes, and worries, rather than lumping them together in one *factual content* category. It may prove valuable for future researchers to distinguish between the frequency of therapist responses that focus on information gathering related to situational details as a means to better understand the clients' discussion of trauma versus engaging the client in cognitive processing related to facilitating PTG. By practicing coding on a "test" sample rather than using the coding system first with the study's target subjects, additional client sessions could be used to establish a more comprehensive set of criteria for each code and therefore be more inclusive and clearly defined when using the coding system with the study's target sample.

Another way to accomplish this goal is to examine how therapists assist clients in achieving PTG in therapy, either during the therapy process or as an outcome. To look at process, qualitative studies using interviews with open-ended inquiry may provide more observation of the PTG process than from one theory as was done in the present study. Such studies could focus on clients' perceptions of growth, targeting ways in which their lives have

changed as result of their traumas, positive life changes or benefits resulting from their experience of traumas, and how therapy. This methodology can provide a rich exploration of clients' perceived dimensions of growth that may be otherwise biased when using self-report measures that are categorized into domains of PTG using post hoc analyses guided by authors' use of various definitions of growth already found in the research literature.

At the same time, however, coding and analyzing qualitative data may be time consuming, and may not be feasible for conducting studies with large samples of individuals obtaining psychotherapy services from trainee-based community counseling centers. Because quantitative studies examining growth among individuals who have experienced trauma and adversity have primarily used self-report instruments as measures of growth, they may be another viable option for future study of PTG among the trainee therapist population. Unlike qualitative studies, quantitative measurement would allow researchers to conduct larger-scale studies, as opposed to studying a sample of only several participants, and may be more feasible in quickly assessing potential PTG among clients while they are still in therapy with their therapists at community counseling centers, and after therapy termination/transition. For example, self-report measures such as the PTGI can be administered with other clinic measures already periodically given, and therapists can discuss with their clients in session the perceptions of growth and change indicated on self-report growth measures. This way, potential positive bias in how assessment measure items were derived or worded in addition to the retrospective report of growth may be better controlled for when the client and therapist talk about them together in detail after completing the measure. It would also eliminate the potential coder bias of identifying or not identifying growth that exists when performing in depth qualitative research. Additionally, discussion of

self-report measures together in session may also more easily help the therapist facilitate PTG in session, and use Calhoun and Tedeschi's (1999) recommended counseling strategies to do so.

Future research should examine the possibility of vicarious trauma among trainee therapists and how it may contribute to the extent to which trainee therapists may avoid helping the client to process emotions related to his or her trauma. For example, qualitative interviews could be conducted with therapists about how they feel about and are impacted by inquiring about their clients' experiences of trauma, their self-care and coping mechanisms for dealing with stress, as well if they have or are experiencing symptoms of vicarious trauma. Supervisors of trainee therapists may also want to use an assessment tool such as the Traumatic Stress Institute Belief Scale Revision L (TSI-BSL) to measure the disruptions in beliefs about self and others that arise from psychological trauma or from vicarious exposure to trauma material through psychotherapy (Deville, Wright, & Varker, 2009).

Given the implications of this study that trainee therapists may appear to benefit from additional training in utilizing clients' strengths in an effort to help them recover and grow from their experiences of trauma, the development and evaluation of a manual appears indicated. The basis of the manual would be the operational definitions of therapist response codes created by this study that were derived from Calhoun and Tedeschi's (1999) counseling recommendations. In addition, the manual would incorporate *encouraging support* responses consistent with those found in this study and in Briere and Scott's (2006) guide to recovery and growth from trauma. To that end, therapists should also inquire about their clients' spiritual beliefs and social support, as Calhoun and Tedeschi suggest doing so early in therapy as a means to potentially promote the PTG process later in psychotherapy.

Another potential contribution to the manual could come from other studies in which therapists' perspectives were gathered through interviews or surveys about (a) whether or not they think clients can grow in addition to recover from trauma, (b) how and if they think they utilize PTG-based counseling strategies (if so, where they learned them), and (c) ways in which it might be helpful for them to learn such strategies (e.g., workshops, supervision, coursework). Because potential vicarious traumatization and issues pertaining to trainee therapist feelings of competence were also of interest related to the discussion of findings for this study, training clinics may also benefit from including in the aforementioned manual literature about trainee therapist discomfort and feelings of competence as it relates to working with clients with trauma, since it may impact the development of vicarious trauma and negatively impact the way they relate to their clients. It is hoped that the addition of this information in a manual may educate trainee therapists about potential feelings and responses toward their clients as well as help normalize their experiences in order to reduce anxiety incurred from working with traumatized clients. This way, trainee therapists may have more confidence and be better prepared to assess and observe potential opportunities for growth.

To determine whether the manual may prove valuable in assisting future trainee clinicians to help their clients experience recovery and growth through their struggles with trauma, performing a similar study to the current one to examine use of strategies, in addition to qualitatively interviewing therapists who have been exposed to the manual as well as therapists who have not, may help elucidate therapists' experiences and use of strength and PTG-related counseling strategies. In addition, therapists could also assess whether PTG was an outcome of therapy by periodically providing assessment measures such as the PTGI to assess for clients' potential growth over time.

Contributions

As it aims to help create a science of human strength as a means for prevention rather than merely treatment of psychological disorders (Seligman, 2005), positive psychology seeks to focus on strengths and virtues rather than solely on pathology, weakness, and damage (Seligman & Csikszentmihalyi, 2000). Similarly, the field of trauma is increasingly focusing its attention on positive outcomes that arise from adversity (Sheikh, 2008), such as PTG, as well as strength-based approaches to treatment. Inspired by these movements, the researcher felt it was important to help elucidate how therapists early in their training employ strengths-based approaches such as those suggested by Calhoun and Tedeschi (1999) when working with clients who have experienced trauma.

The primary way that this study contributed to current theories and research on PTG as it applies to psychotherapy was through the development and use of a coding system to empirically examine the theoretical recommendations of Calhoun and Tedeschi (1999). No research has been conducted on these recommendations before this study. Thus, the codes used/derived for this study allow other researchers and clinicians a basis on which they can further investigate therapist practices in larger samples in a systematic, replicable way.

In addition, the results of this qualitative study can inform modifications to the Recommendations. This study indicated that Calhoun and Tedeschi's (1999) recommendations for facilitating PTG may benefit from being expanded to fully capture additional ways in which the growth process from the struggle with trauma may be influenced. More specifically, their Recommendations should include: (a) social support, (b) cultural and spiritual beliefs and practices, (c) Briere and Scott's (2006) suggestions for reframing traumatic experiences as areas for growth, (d) therapist self-disclosures similar to therapist personal supportive opinions, and (e)

therapist encouraging responses. By expanding an existing PTG theoretical approach to working with clients, it is hoped that this study contributes to a more complete and balanced scientific understanding of how actual trainee therapists may attempt to facilitate human thriving.

Understanding how trainee therapists may or may not facilitate aspects of the PTG process can inform how and to what extent therapists may promote growthful experiences among individuals suffering from trauma and adversity, and what they might need in terms of training to accomplish this goal. An implication from this study was that therapists early in their training may have difficulty with the emotional processing involved in working with clients who have experienced trauma, but their focus on listening may still assist clients in growth-related experiences. Either way, graduate training in the use of counseling strategies to promote PTG with clients who have struggled with trauma is highly recommended. Such training could be informed by our codes and results from this study as part of an educational or treatment manual as described in the previous section.

In addition, this study reminds us that clients may be their own agents of change. It was noted that the clients themselves may have been moving in their own direction toward experiencing growth, based (a) on their openness to change and active engagement, (b) because of their cultural or spiritual beliefs, as well as (c) social support provided to them by family and by the therapists themselves.

In sum, it is hoped that this study contributed to the positive psychology and trauma literature by providing further insight and ways to facilitate strength and positive changes following trauma and adversity as a means for clients to flourish rather merely just recover from trauma. The contributions of the current study, in an attempt to gain a better understanding and provide further direction for facilitating PTG in psychotherapy, may contribute to what

Frederickson (2003) believes to be discoveries by positive psychology that may improve individual and collective functioning, psychological well-being and physical health (Frederickson, 2003). Thus, it is hoped that through the current study, trainee therapists may better learn how to build upon the qualities that help individuals and communities not just endure and survive trauma, but also flourish, and experience a life worth living.

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APPENDIX A

Client Information Adult Form

ID # _____

CLIENT INFORMATION **ADULT FORM

THIS FORM IS INTENDED TO SAVE YOU AND YOUR INTAKE INTERVIEWER TIME AND IS IN THE INTEREST OF PROVIDING YOU WITH THE BEST SERVICE POSSIBLE. ALL INFORMATION ON THIS FORM IS CONSIDERED CONFIDENTIAL. IF YOU DO NOT WISH TO ANSWER A QUESTION, PLEASE WRITE "DO NOT CARE TO ANSWER" AFTER THE QUESTION.

TODAY'S DATE _____

FULL NAME _____

HOW WOULD YOU PREFER TO BE ADDRESSED? _____

REFERRED BY: _____

MAY WE CONTACT THIS REFERRAL SOURCE TO THANK THEM FOR THE REFERRAL? YES NO

IF YES, PLEASE PROVIDE CONTACT INFORMATION FOR THIS PERSON/AGENCY

Personal Data

ADDRESS: _____

TELEPHONE (HOME): _____ BEST TIME TO CALL: _____ CAN WE LEAVE A MESSAGE? Y N

(WORK): _____ BEST TIME TO CALL: _____ CAN WE LEAVE A MESSAGE? Y N

AGE: _____ DATE OF BIRTH: ____/____/____

MARITAL STATUS:

MARRIED SINGLE HOW LONG? _____

DIVORCED COHABITATING PREVIOUS MARRIAGES? _____

SEPARATED WIDOWED HOW LONG SINCE DIVORCE? _____

LIST BELOW THE PEOPLE LIVING WITH YOU:

NAME	RELATIONSHIP	AGE	OCCUPATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:
NAME: _____

ADDRESS: _____

TELEPHONE: _____

RELATIONSHIP TO YOU: _____

Medical History

CURRENT PHYSICIAN: _____

ADDRESS: _____

CURRENT MEDICAL PROBLEMS: _____

MEDICATIONS BEING TAKEN: _____

PREVIOUS HOSPITALIZATIONS (MEDICAL OR PSYCHIATRIC)

DATE

OTHER SERIOUS ILLNESSES

DATE

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

DATE

Educational and Occupational History

HIGHEST LEVEL OF EDUCATION ATTAINED:

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

SELF HARM (CUTTING, BURNING)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DEBILITATING ILLNESS, INJURY, OR DISABILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PROBLEMS WITH LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ACADEMIC PROBLEMS (DROP-OUT, TRUANCY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FREQUENT FIGHTS AND ARGUMENTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
INVOLVEMENT IN LEGAL SYSTEM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
CRIMINAL ACTIVITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
INCARCERATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Current Difficulties

PLEASE CHECK THE BOXES TO INDICATE WHICH OF THE FOLLOWING AREAS ARE CURRENT PROBLEMS FOR YOU AND REASONS FOR COUNSELING.

PLACE TWO CHECK MARKS TO INDICATE THE MOST IMPORTANT REASON(S).

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

ADDITIONAL CONCERNS (IF NOT COVERED ABOVE):

Social/Cultural (Optional)

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

APPENDIX B

Intake Evaluation Summary

Pepperdine Psychological and Educational Clinic

Intake Evaluation Summary

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

I Identifying Information

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

II Presenting Problem/Current Condition

(Description of client's current difficulties, and why s/he is seeking help at this time; describe symptoms and impact on current functioning, including onset, frequency and duration)

III History of the Presenting Problem & History of Other Psychological Issues

(Trace development of present problem, including previous psychological treatment, hospitalizations, medication; discuss other significant psychological difficulties and prior treatment. Address history of substance abuse, suicidal ideation/attempts, & aggressive/violent behavior)

IV Psychosocial History

A Family History

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

B Developmental History

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

C Educational/Vocational History

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

D Social Support/Relationships

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

E Medical History

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

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

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

G Legal History

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

V Mental Status Evaluation

Hygiene & grooming:

Interpersonal presentation/behavioral observations:

Orientation (person, place, time, situation):

Speech (pitch, pace, tone):

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

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

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

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

Thought Content (appropriate; delusions; odd ideations):

Perceptual Disturbances (hallucinations):

Cognitive Functioning (intellectual functioning, fund of knowledge):

Concentration, Attention & Memory:

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

VI Client Strengths

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

VII Summary and Conceptualization

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

VIII DSM-IV TR Multiaxial Diagnosis

Axis I:

Axis II:

Axis III:

Axis IV:

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

Current GAF:

Highest GAF during the past year:

IX Client Goals

X Treatment Recommendations

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

Intake Therapist

Supervisor

Date

APPENDIX C

Telephone Intake Form

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

ID# _____

Pepperdine Community Counseling Center Telephone Intake Interview

Caller Information

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

WHAT IS YOUR NAME?: _____

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

_____ M F DOB: _____ AGE: _____

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

WHAT IS (CLIENT'S) ADDRESS?: _____

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

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

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

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

WHO DOES (CLIENT) LIVE WITH? SELF OTHERS -

LIST: _____

DOES (CLIENT) HAVE CHILDREN?: _____

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

sample

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

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

Type of Service

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

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

8/7/08 1

ID# _____

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

Reason for Referral

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

sample

ARE THERE ANY PAST OR CURRENT LEGAL PROBLEMS? Y N _____
IS THERE A COURT ORDER THAT REQUIRES TREATMENT? Y N _____
FOR WHAT REASON? _____
CLIENT TOLD LIMITS REGARDING COURT ORDERS? Y N _____
ARE THERE ANY PAST OR CURRENT DRUG AND/OR ALCOHOL PROBLEMS? Y N _____

ANY CURRENT THOUGHTS OF HURTING YOURSELF? Y N _____
ANY PREVIOUS THOUGHTS OR ATTEMPTS AT HURTING YOURSELF? Y N _____
IF SO, WHEN WAS THE LAST TIME YOU *THOUGHT* ABOUT HURTING YOURSELF?: _____
WHEN WAS THE LAST TIME YOU *ATTEMPTED* TO HURT YOURSELF?: _____
DO YOU FEEL OR HAVE OTHERS SUGGESTED THAT YOU HAVE A "BAD TEMPER" OR THAT YOU GET MAD EASILY? Y N _____
IF SO, PLEASE PROVIDE EXAMPLES: _____
ANY PAST VIOLENCE TOWARDS OTHERS? Y N _____

ID# _____

ARE YOU CURRENTLY OR HAVE YOU EVER SEEN A PSYCHIATRIST, PSYCHOLOGIST, OR COUNSELOR?:

IF SO, ASSESS WHEN, WHERE, HOW LONG, TYPE (INPATIENT/HOSPITALIZATION OR OUTPATIENT)

ARE YOU CURRENTLY OR HAVE YOU EVER TAKEN PSYCHIATRIC MEDICATION?:

IF SO, LIST: _____

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

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

WHO IS THE CHILD'S PRIMARY CAREGIVER?: _____

WHO HAS LEGAL CUSTODY OF THE CHILD?: _____

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

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

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

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

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

IS YOUR CHILD COMING VOLUNTARILY/WILLINGLY? Y N

Occupation and Fees

ARE YOU CURRENTLY WORKING OR GOING TO SCHOOL? Y N

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

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

WHAT IS (CLIENT'S) OCCUPATION?: _____

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

Intake Interviewer Checklist

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

8/7/08 2

ID# _____

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

sample

APPENDIX D

Treatment Summary Form

Diagnosis at Termination:

Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

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

sample

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

Student Therapist

Supervisor

Date

Date

Revised 4-15-2009

APPENDIX E

Coding Manual

RESEARCH PROJECT CODING MANUAL

This training manual is intended to describe the methods of transcription and coding that will be utilized for the team's dissertation research projects. The specific therapy tapes used in the projects will be of clients and therapists at Pepperdine University clinics selected based on inclusion/exclusion criteria (e.g., individual adult clients representing diverse ethnicities, genders, religions, and presenting issues).

Renee Sloane, M.A., Ani Khatchadourian, M.A., and Chris Howells, M.A. (researcher-participants) will be using this data for their respective dissertations to gain a more in-depth understanding of how clients discuss trauma in therapy. Research assistants will transcribe videotaped psychotherapy sessions containing discussions of trauma identified by the researcher-participants.

This manual has 4 sections:

- I. CODING TIMING OF TRAUMA DISCUSSION INSTRUCTIONS
- II. TRANSCRIPTION INSTRUCTIONS
- III. CODING OVERVIEW
- IV. CODING STEPS FOR RESEARCHER-PARTICIPANTS

I. CODING TIMING OF TRAUMA DISCUSSION INSTRUCTIONS

The first step involves the researcher-participants identifying when trauma discussions take place during the videotapes psychotherapy session. This involves understanding the definitions of trauma as well as discussions about it.

Definition of Trauma

A broad definition of trauma includes threats to one's psychological integrity (Briere & Scott, 2006), as well as one's reactions and responses to the events themselves (Hall & Sales, 2008). Briere and Scott suggest that trauma applies to both threats to *psychological* integrity and threats to *physical* integrity, whereas definitions of trauma in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association [APA], 2000) only apply to threatened *physical* integrity to meet criteria for a traumatic stress diagnosis.

To capture the more conservative definition of trauma as an event that threatens one's physical integrity (Briere & Scott, 2006), traumatic events consistent with DSM-IV-TR criteria in the Family Data Section of the Client Information Adult Form include: Death and Loss, Sexual Abuse, Physical Abuse, Rape/Sexual Assault, Debilitating Illness Injury, or Disability. Events subsumed under the more broad definition of trauma include events that may threaten one's psychological integrity, such as Emotional Abuse and Separation/Divorce.

Definition of Trauma Discussion

Based upon definitions of disclosure in the literature (Chelune, 1979; Cozby, 1973; Jourard, 1971; Omarzu, 2000; Pennebaker, Zech, & Rimé, 2001), discussions of trauma will be

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Uh
- Um
- Uh-huh
- Mm-hmm
- Unh-uh

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

Incomplete sentences are familiar occurrences in oral history because of its conversational nature. They are best ended with an em dash (—). Use one dash (-) for an incomplete word that is then continued (e.g., mo- mother). Interruptions should be indicated using an ellipsis (...).

Similarly, an ellipsis should be used when the person who was interrupted continues their sentence after the interruption.

Example: Interruption

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

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

Interruption and continuation

T1: He was coming toward me and I felt, I felt...

C2: Scared?

T2: ...scared and confused.

Quotation Marks:

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

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

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

Example: They said, What are you doing here?

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

Example: I thought, Where am I?

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

TRANSCRIPTION TEMPLATE

CONFIDENTIAL VERBATIM TRANSCRIPT

Confidentiality: The following is a confidential document, which may contain information that could be detrimental if used by untrained individuals. Nonconsensual disclosure by individuals not associated with Pepperdine University and the Positive Psychology PARC lab is prohibited.

Session Number:

Coder:

Client #:

Date of Session:

C = Client

T = Therapist

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

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

The third step of the process involves the researcher-participant engaging in three distinct coding processes to be completed in the following order: (a) open coding for themes related to trauma, (b) therapist use of autonomy support factors, and (c) therapist use of Calhoun and Tedeschi's (1999) recommended counseling strategies. Operational definitions and codes relevant to each process are discussed in the following sections.

A. Open Coding:

Open coding is a three-part inductive process that involves examining data and organizing it categorically and hierarchically so that it can be organized in a manner that clusters specific groupings of ideas into categories that become increasingly broad. The specific steps of the process involve: a) identifying themes, b) creating categories, and c) abstraction. The researcher begins this process by examining the data and noting themes that emerge naturally. During the first step, the researcher-participant should simultaneously watch the videotapes while reading through the corresponding section in the session transcript. The researcher-participant should make notes and write down all thoughts/ideas about specific themes that emerge in both the content and the process of the therapy session, which answer the research question, in the margins of the transcript. The researcher participant should complete the first stage of this process as many times as necessary (i.e., multiple passes over the data) until he/she feels he/she has captured all of the relevant themes. The following techniques will be used to identify themes: analyzing repetitions in ideas, concepts, or language, the use of metaphors and analogies, transitions in process, non-verbal behaviors, and the presence of indigenous typologies (Ryan & Bernard, 2003).

Non-Exhaustive List of Open Coding Techniques to Identify Themes During Open Coding

Codes	Examples	Comments
<i>Repetitions in Ideas, Concepts, or Language</i>	a) T1: "That sounds really scary" b) T8: "It sounds like you felt afraid"	Consist of topics and language that occurs and reoccurs in the content of the therapist responses (e.g., particular words or phrases).
<i>The Use of Metaphors and Analogies</i>	T: "I wonder if, as your thoughts come to you, you could imagine them as leaves floating by in a stream, passing in and out of consciousness"	This represents therapist's use of symbolic imagery to illustrate or explain thoughts, feelings, behaviors, or experiences in a manner that schematically resonates with the client.
<i>Transitions in Process</i>	T: "While you were talking about your feelings about the car accident, it reminds me of the time we discussed the death of	These consist of naturally occurring shifts or changes in speech. These can include changes in topic, pauses, changes in voice tone, or other verbal or non-verbal

	your father” T5: “You seem to be getting physically uncomfortable. Would it be helpful if we stopped so that you could use some of the relaxation techniques we practiced?”	behaviors that modify the client-therapist process.
Non-verbal Behaviors	T: (silence), (nodding) or “Um-hmm”	These might include therapist silences, gestures, and auditory indications of agreement and disagreement
Indigenous Typologies	T: “What you’re describing is a flashback, and it can consist of feeling as if you are re-experiencing the traumatic event”	These are expressions that are idiomatic and/or colloquial to the speaker. They may reflect culturally, religiously, regionally, etc., specific use of words and phrases that have been used by the therapist, but which may originate from either the therapist or the client.

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

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

During the third stage, abstraction, the researcher-participant begins the process of abstraction, or arranging themes from the transcripts and videotaped sessions hierarchically. Specific sub-themes should be compared and grouped together into more abstract and broader categories that represent an overarching parent theme for the combined themes. The researcher-participants independently each should continue this process, moving back-and-forth between the specific subcategory level and more general levels until each one can no longer break down categories into smaller units that fall within the broader concepts, and can no longer more broadly define themes. At the end of the abstraction process, researcher-participants should compare their hierarchies with one another to evaluate them for similarity as well as disparity. Non-shared themes that are found in this checking process should be analyzed to determine if they can be re-conceptualized under a different theme, or re-categorized under a different category or branch in the hierarchy.

B. Autonomy Supportive Factors:

The second step of the coding process involves the researcher-participant coding autonomy supportive behaviors of the therapist. Operational definitions, codes, and examples of autonomy supportive behaviors can be found in the table below for the researcher-participant to use in coding therapist behaviors in the transcribed sessions: (a) “Unconditional positive regard,” (b) “Empathy,” (c) Egalitarianism/Providing choices,” (d) “Psychoeducation,” (e) “Empowerment,” and (f) “Core Values.”

Coding System for Identifying Therapist Autonomy Supportive Factors

Identifying Use of Autonomy Supportive Factor *Unconditional Positive Regard*

Code	Example	Comments
Validation (Code UPR)	T: “Of course you are going to feel angry towards the man who violated you.”	The therapist explicitly states that the client is entitled to think, feel, and/or behave in the way that he or she is or wants to

Identifying Use of Autonomy Supportive Factor *Empathy*

Codes	Examples	Comments
Reflecting Fact (Code EMP1a)	T: “So what I’m hearing is that you kind of grew up in a warzone.” T: “What you’re saying is that there was never really someone you could look up to when you were growing up.”	The therapist reflects or rephrases or restates the client’s content or <i>factual</i> utterance Differential: EMP4a takes precedence over EMP1a if therapist response could be interpreted as both
Reflecting Emotion (Code EMP1b)	T: “It sounds like you felt ashamed when you told your mother about what your step-father was doing to you.”	The therapist reflects or rephrases or restates the client’s feelings or <i>emotional</i> utterance about client’s own experience Differential: EMP4b takes precedence over EMP1b if therapist response could be interpreted as both
Reflecting Ambiguous Fact/Feeling (Code EMP1c)	T: “It must have been really hard for you to go through that at such a young age.” T: “You seem to have a pattern of worrying about others.”	The therapist reflects or rephrases or restates the client’s verbalizations about client’s own experience; the verbalizations are neither clearly a fact nor an emotion.
Nonverbal Referent (Code EMP2)	T: “I notice that when you talk about what your step-father did to you, you	The therapist reflects or rephrases or restates the client’s aspects of <i>nonverbal</i> behavior

	quickly change the subject and look away from me.”	
Shared Feeling or Experience (Code EMP3)	T: “There was a time after my mother passed away that I had a hard time seeing other mothers and daughters spend time together.”	Therapist self-discloses, making an explicit statement that he or she either shares the client’s emotion or has had/would have a similar experience
Understanding of Content – Cognitive (Code EMP4aTx:Ty)	T: “So I’m curious, how much time do you spend thinking about your step-father?” C: “I usually can’t fall asleep every night because my memories of him are on my mind.” T: “Wow, so you do think about him quite a bit.”	The therapist verbally communicates accurate understanding of the client’s <i>thoughts</i> or <i>situation</i> by probing, with explicit questions, to understand more fully and reflecting verbal understanding back to client (both parts must be present within two consecutive therapist verbal talk-turns to receive this code) Differential: This is a higher order conveyance of empathy than EMP1a; EMP4a takes precedence if therapist response could be interpreted as both.
Understanding of Content – Affective (Code EMP4bTx:Ty)	T: “What was that like for you? How did it feel to have people afraid of you?” C: “It felt really empowering.” T: “So part of you liked that people were afraid of you.”	The therapist verbally communicates accurate understanding of the client’s <i>feelings</i> by probing, with explicit questions, to understand more fully and reflecting verbal understanding back to client (both parts must be present within two consecutive therapist verbal talk-turns to receive this code) Differential: This is a higher order conveyance of empathy than EMP1b; EMP4b takes precedence if therapist response could be interpreted as both.
Understanding of Content – Ambiguous Fact/Feeling	T: “So did you feel like you worried about him all the time?” C: “Um, I’m not sure. I feel like I was just always worrying about everything.” T: “Yeah. Hmm, so it sounds like you felt like you could never have peace of mind.”	The therapist verbally communicates accurate understanding of the client’s verbalizations by probing, with explicit questions, to understand more fully and reflecting verbal understanding back to client; the verbalizations are neither clearly a fact nor an emotion (both parts must be present within two consecutive therapist verbal talk-turns to receive this code). Differential: This is a higher order conveyance of empathy than EMP1c; EMP4c takes precedence if therapist response could be interpreted as both.

Identifying Use of Autonomy Supportive Factor *Egalitarianism/Providing Choices*

Codes	Examples	Comments
<i>Providing Choices – Therapeutic Material</i> (Code EgPc1)	T: “So, I’m curious what you would like to talk about today?” T: “We don’t have to talk about that if you’re uncomfortable with it. We can talk about anything you’d like.”	Therapist provides choices or allows client to direct decision-making in the context of material being discussed in sessions Note: This code relates to material <i>within</i> the therapy session
<i>Providing Choices – Administrative</i> (Code EgPc2)	T: “Well, I can either be really directive with you, or I can take more of a ‘sit back and listen’ approach. It’s up to you.” T: “Would you feel more comfortable coming in every other week instead?”	Therapist provides choices or allows client to direct decision-making in the context of issues related to the delivery of psychotherapy services, such as appointment time, intervention options, etc.

Identifying Use of Autonomy Supportive Factor *Psychoeducation*

Codes	Examples	Comments
<i>Providing Information – Symptoms, Theory, Treatment</i> (Code PSY)	T: “It is common for people who have been through what you have to avoid certain triggers of memories of the event.” T: “It sounds like everything you’re experiencing is connected, and explains how you got here in one piece.” T: “There is a type of therapy approach called mindfulness skills training that might be really helpful for you to be in the present moment and not worry so much about the future.”	Therapist provides information that helps to clarify the cause or effect of client’s symptoms and presenting problem in order for client to become more aware and in control of his or her experience; therapist provides information regarding prognosis and/or treatment (or any additional services related to treatment) fully and carefully so that client may have awareness and control of his or her own experience; therapist provides information regarding a psychological theory

	T: “Having that psychological assessment done can really help clarify some of the symptoms you have been experiencing.”	
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Identifying Use of Autonomy Supportive Factor *Empowerment*

Codes	Examples	Comments
<i>Conveying Confidence in Ability to Make Changes – Competence</i> (Code EPW1)	T: “I remember you told me that you left your dad’s house as a teen because of the abuse. I really believe that if you could do that then, you can walk away from our current abusive relationship as well.” T: “You learned very early on to be a strong and independent woman.”	Therapist verbally communicates confidence in the client’s ability to make changes in a positive direction and/or reinforces strengths and positive characteristics of the client
<i>Emphasizing Control</i> (Code EPW2)	T: “What do you think the best decision would be for you?” T: “Well, how do <i>you</i> think you should handle the situation with your brother?” T: “You are the only one that can decide that for yourself.”	Therapist directly acknowledges or emphasizes the client’s freedom of choice, autonomy, and right to make decisions. Therapist emphasizes or implies that no one, including therapist, knows client as well as he or she knows him- or herself. Therapist refrains from an authoritarian approach of being directing or ordering and instead promotes the decision-making abilities of the client

Identifying Use of Autonomy Supportive Factor *Core Values*

Codes	Examples	Comments
<i>Identifying/Clarifying Personal Values</i> (Code CV1)	T: “So it sounds to me like it is really important for you to be close to your family and feel like you are really connected with them.” T: “When you look at your life today, there are some things you like, like your integrity.”	Therapist helps client explore what is most important to him or her, what sort of person he or she is or wants to be, what is significant and meaningful, and what he or she wants his or her life to stand for Note: This code may overlap with EMP1a or EMP1b

	T: "I'm curious how much do you not trust other people?"	
Committed Action – Setting Goals (Code CV2a)	T: "This week, your goal can be to spend three nights with our parents, even though it might feel uncomfortable for you at first and you might start feeling anxious." T: "I'm curious how you envision that changing for you?"	Therapist helps client set behavioral goals that are guided by his or her values
Committed Action – Effective Action (Code CV2b)	T: "In order for you to meet your goal, what are the kinds of things you will need to that day to prepare for dinner with your parents?"	Therapist helps client articulate plan and steps to take effective action to achieve goals

C. The third step of the process involves the researcher-participant coding the use of Calhoun and Tedeschi's (1999) counseling strategies.

Operational definitions, codes, and examples of the following counseling strategies recommended by Calhoun and Tedeschi (1999) are located in the table below for the researcher-participant to use in coding therapist responses in the transcribed trauma discussions: (a) "Focus on listening without necessarily trying to solve," (b) "Label growth when it is there," (c) "Events that are too horrible," and (d) "Choosing the right words".

Coding System for Identifying Calhoun and Tedeschi's (1999) Counseling Strategies

Identifying Use of a Counseling Strategy *Focus on listening without trying to solve*

Codes	Examples	Comments
Minimal Encouraging (Code FL1)	T: "Uh-um" or "Yes," or nodding	Consist of all short utterances that the therapist does automatically such as saying "Uh-um" or "Yes,, or nodding
Direct Encouraging (Code FL2)	T: "Go on... Tell me more about that night of the rape."	The therapist explicitly encourages the other to continue talking, such as saying "Go on," "Continue, or "Tell me more"
Reflecting Fact (Code FL3a)	T: "So you went to your mother's house after the rape, and then called the police."	The therapist reflects or rephrases or restates the client's content or <i>factual</i> utterance in one's own words

		Note: Reflection should occur within two consecutive therapist talk turns immediately following client's talk turn
Reflecting Emotion (Code FL3b)	T: "So you were feeling really scared at the time you decided to go to your mother's house before calling the police."	The therapist reflects or rephrases or restates the client's feelings or <i>emotional</i> utterance in one's own words Note: Reflection should occur within two consecutive therapist talk turns immediately following client's talk turn
Reflecting Ambiguous Fact/Emotion (Code FL3c)		
Nonverbal Referent (Code FL3d)	T: "I'm noticing that as you're telling me about the rape, you're really anxious—you're shaking and it's hard for you to look at me."	The therapist reflects or rephrases or restates the client's aspects of <i>nonverbal</i> behavior in one's own words
Questioning on Fact- Open Code FL4aF-O	T: "So you had been drinking a lot that night at the bar. Can you tell me more about that?"	Open questions are defined as those in which the therapist requests clarification or exploration without purposely limiting the nature of the response; excludes rhetorical questions
Questioning on Fact- Closed Code FL4cF-C	T: "How many drinks did you have that night?"	Closed questions elicit specific and limited information from the client, usually requesting a one- or two-word answer such as "yes" or "no" as confirmation of the therapist's previous statement; excludes rhetorical questions
Questioning on Emotion-Open Code FL4bE-O	T: "How were you feeling that night before you started drinking at the bar?"	Open questions are defined as those in which the therapist requests clarification or exploration without purposely limiting the nature of the response; excludes rhetorical questions
Questioning on Emotion-Closed Code FL4dE-C	T: "Were you feeling sad or lonely at the time you went to the bar?"	Closed questions elicit specific and limited information from the client, usually requesting a one- or two-word answer such as "yes" or "no" as confirmation of the therapist's previous statement; excludes rhetorical questions
Questioning on		

Ambiguous Fact/Emotion Code FL4amb-C/O		
Trying to solve-Treatment Intervention Code FLTS-I	T: "Next time you are starting to feel panic before a work meeting, I want you to stop what you are doing and take 10 deep breaths."	Therapist provides a treatment focused recommendation as to an appropriate choice of action regarding a situation or problem
Trying to solve-Personal advice/Opinions Code FLTS-A	T: "I don't think it's a good idea for you to leave the bar alone after having so many drinks."	Therapist provides a personal judgment, belief, or conclusion held with confidence but not necessarily substantiated by positive knowledge or proof regarding an appropriate choice of action regarding situation or problem
Trying to solve-Ambiguous Code FLTS-Amb	T: "I really like the idea of you calling your mother twice per week in order to increase contact with her and to reduce your stress with the child care."	Therapist provides what may appear to be both personal judgment and a therapeutic intervention.
Not Otherwise Specified Code NOS		Any therapist response that does not fit into a <i>any</i> specific PTG recommendation category, but appears closely related enough to warrant attention and further analysis

Identifying Use of a Counseling Strategy *Label growth when it is there*

Codes	Examples	Comments
Therapist verbalized positive changes that the client identified as already present (Code LGa)	C: In the past six months I've noticed that my wife has been more patient with me and has been really supportive. I am starting to realize that maybe I have underestimated her." T: "So through this experience, your wife has been more supportive than you otherwise thought her to be."	Positive changes are defined as a transformation or transition from one state, condition, or phase to another, tending towards progress or improvement

<p><i>Therapist reframed the way the client viewed certain events in a new, positive way</i> (Code LGb)</p>	<p>C: In the past six months I've noticed that my wife has been more patient with me and has been really supportive. I am starting to realize that maybe I have underestimated her.”</p> <p>T: “It sounds like one of the things you are discovering is that, at least in some ways, your illness and discomfort have served to bring you and your wife a little closer together.”</p>	<p>Reframe is defined as to look at, present, or think of (thoughts, beliefs, ideas, relationships, etc.)</p>
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Identifying Use of a Counseling Strategy *Events that are too horrible*

Codes	Examples	Comments
<p><i>Therapist shared with the client that some individuals stated they have changed in some positive ways as they coped with their trauma</i> (Code EHa)</p>	<p>T: “Some people have found that through their struggle with their grief over the loss of their spouse, they have experienced some positive changes in their lives.”</p>	<p>Change in positive ways is defined as transforming from one state, condition, or phase to another, tending towards progress or improvement</p>
<p><i>Therapist elicited whether the client thought that this was possible for him/her given what he/she has gone through</i> (Code EHb)</p>	<p>T: “Some people have found that through their struggle with their grief over the loss of their spouse, they have experienced some positive changes in their lives. Have you ever felt that way given what you have gone through?”</p>	<p>Change in positive ways is defined as transforming from one state, condition, or phase to another, tending towards progress or improvement</p>

Identifying Use of a Counseling Strategy *Choosing the right words*

Codes	Examples	Comments
<p><i>Therapist reinforced the positive interpretations of growth or positive changes coming from the struggle with trauma when the client made them</i> (Code CWa)</p>	<p>C: Since Amanda's death, I've been trying to help other women who have lost a child by creating a support group.”</p> <p>T: “It seems that your struggle with Amanda's</p>	<p>Reinforced is defined as the therapist emphasizes, stresses, or supports when the client explains a positive meaning, significance, or change resulting from his or her struggle with trauma; the term “positive” refers specifically to indications of growth rather than just returning to</p>

	death has led you to be more committed to helping others avoid your kind of pain.”	psychological baseline Note: CWa differs from CWb in that CWa is client-initiated
<i>Therapist chose to label or identify client statements reflecting posttraumatic growth with words that reflected the individual’s struggle to survive and come to terms with the event, as opposed to the event itself</i> (Code CWb)	C: Amanda’s death led me to become more aware of the simple things in life that I took advantage of before, like the importance of spending time with my nieces and nephews.” T: “Your <i>struggle</i> with the pain produced by Amanda’s loss has led you to be more committed to spending time with your family.”	Label is defined as the therapist describing or recognizing client statements reflecting his or her struggle to survive. Words synonymous with <i>struggle</i> include <i>strive, carry on, fight, wrestle, grapple, battle, contend, go up against, or put up a fight</i> . Coming to terms with the event is defined as starting to accept and deal with a difficult situation Note: CWb differs from CWa in that CWb is therapist-initiated

Coding Steps for Researcher-Participants

1. Watch the videotape of trauma discussions and read the transcript all of the way through to make sure that the transcript is accurate. Familiarize yourself with the content and process of the session.
2. When coding, you want to **try to balance attention to details with an ability to think abstractly** and see the bigger picture. It is also important to maintain focus by pacing yourself carefully. It is difficult to code accurately when you are rushed or code in binges. In the discussion meetings, it helps to present your questions and confusions and to agree with others only when the consensus makes sense. Coding requires an **openness and flexibility but not acquiescence**.
3. Familiarize yourself with the open coding steps of a) identifying themes, b) creating categories, and c) abstraction. Then, begin the coding process, simultaneously using reading the written session transcriptions and watching the corresponding session videotape
4. Familiarize yourself with coding steps for (a) use of Calhoun and Tedeschi’s counseling strategies and (b) autonomy support factors.
5. Begin the directed coding process for (a) use of Calhoun and Tedeschi’s counseling strategies and (b) autonomy support factors.

6. Individually, read the transcript again in detail by looking at each statement (T1, T2, etc.) and write your coding impressions on the right hand column of the transcript sheet.
7. Meet with team of coders to discuss codes and determine inter-rater reliability. Codes that meet (66%) agreement will be chosen as final codes and recorded on data tracking sheet.
8. Provide auditor with final codes to determine whether the data reflective of the codes has been abstracted by the coders. The auditor will facilitate discussion with the coders regarding discrepancies that arise with the team's judgment, and provide suggestions for changes.
9. Final codes will be entered into the Excel data-tracking sheet for further analysis.

APPENDIX F

Client Consent Form

Pepperdine University

Counseling and Educational Clinics Consent for Services

INITIALS →

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

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

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

I understand and agree with the above three statements.

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

Psychotherapy: The first few sessions of therapy involve an evaluation of your needs. At the end of the evaluation phase, a determination will be made regarding whether our services appropriately match your mental health needs. A determination will also be made regarding whether to continue with services at our clinic, or to provide you with a referral to another treatment facility more appropriate to your needs. As part of your services, you will be asked to complete questionnaires during your intake session, at periodic intervals (e.g., every fifth session), and after you have completed treatment.

Psychotherapy has both benefits and risks. Risks sometimes include being asked to discuss unpleasant aspects of your life and experiencing uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Sometimes decisions are made in therapy that are positive for one family member and can be viewed negatively by another family member. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. But there are no guarantees of what you will experience. In order for therapy to be effective, a commitment to regular attendance is necessary. Frequent cancellations or missed therapy appointments may result in termination of services or a referral to an alternative treatment setting. Unless otherwise arranged, therapy sessions are scheduled once a week for 50 minutes. Educational Therapy is also offered in some of our clinics. This is an intervention that focuses on learning difficulties by addressing how circumstances in a person's life contribute to these difficulties. Educational therapy combines tutoring as well as attention to socio-emotional issues that affect learning.

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

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

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

_____ Video/audio taping
_____ Direct Observation

Psychological Research: As a university based clinic, we engage in research activities in order to determine the effectiveness of our services, including client satisfaction, as well

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

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

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

_____ Written Data
_____ Videotaped Data
_____ Audiotaped Data

OR

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

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

OR

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

Fees: The fee for the initial intake is nonrefundable.

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

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

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

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

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

- If the clinic has formal business associates who have signed a contract in which they promise to maintain the confidentiality of your information except as specifically allowed in the contract or otherwise required by law.

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

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

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

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

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

Treatment & Evaluation of Minors:

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

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

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

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

and/or

Signature of parent or guardian

Relationship to client

Signature of parent or guardian

Relationship to client

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

Clinic/Counseling Center
Representative/Witness

Translator

Date of signing

APPENDIX G

Therapist Consent Form

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

1. I, _____, agree to participate in the research database project being conducted under the direction of Drs. Eldridge, Ellis, and Hall, in collaboration with the clinic directors. I understand that while the study will be under the supervision of these Pepperdine GSEP faculty members, other personnel who work with them may be designated to assist or act in their behalf. I understand that my participation in this research database is strictly voluntary.
2. One purpose of research at the Pepperdine University GSEP Clinics and Counseling Centers is to examine the effectiveness of new clinic policies and procedures that are being implemented. This is being done through standard internal clinic practices (headed by the clinic directors and the Clinic Advancement and Research Committee) as well as through the construction of a separate research database (headed by Drs. Eldridge, Ellis, and Hall). Another purpose of this research project is to create a secure database from which to conduct research projects by the faculty members and their students on other topics relevant to clinical practice.
3. I have been asked to participate in the research database project because I am a student therapist or intern at a GSEP Clinic or Counseling Center. Because I will be implementing the new clinic policies and procedures with my clients, my input (or participation) will provide valuable data for the research database.

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

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

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

- I understand and agree that the following information will be included in the Research Database (check all that apply).
 - _____ Written questionnaires about my knowledge, perceptions and reactions to clinic trainings, policies and procedures
 - _____ Written Data about My Clients (e.g., Therapist Working Alliance Form)
 - _____ Video Data of sessions with my clients (i.e., DVD of sessions)
 - _____ Audio Data of sessions with my clients (i.e., CD or cassette tapes of sessions)

OR

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

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

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

OR

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

- _____
4. My participation in the study will last until I leave my position at the GSEP Clinic or Counseling Center.
 5. I understand that there is no direct benefit from participation in this project, however, the benefits to the profession of psychology and marriage and family therapy may include improving knowledge about effective ways of training therapists and implementing policies and procedures as well as informing the field about how therapy and assessments are conducted in university training clinics.
 6. I understand that there are certain risks and discomforts that might be associated with this research. These risks include potential embarrassment or discomfort at having faculty review materials about my clinic practices, which may be similar to feelings about supervisors reviewing my work; however this risk is unlikely to occur since the written materials will be coded to protect your identity. Sensitive video data will be also coded to protect confidentiality, tightly secured (as explained below), and reviewed only by those researchers who sign strict confidentiality agreements.
 7. I understand that I may choose not to participate in the research database project.
 8. I understand that my participation is voluntary and that I may refuse to participate and/or withdraw my consent and discontinue participation in the research project at any time without prejudice to my employment in the GSEP Clinics and Counseling Centers. I also understand that there might be times that the investigators may find it necessary to end my study participation (e.g., if my client withdraws consent for participation in the research study).
 9. I understand that the investigators will take all reasonable measures to protect the confidentiality of my records and my identity will not be revealed in any publication that may result from this project.

10. The confidentiality of my records will be maintained in accordance with applicable state and federal laws. Under California law, there are exceptions to confidentiality, including suspicion that a child, elder, or dependent adult is being abused, or if an individual discloses an intent to harm him/herself or others. I understand there is a possibility that information I have provided regarding provision of clinical services to my clients, including identifying information, may be inspected and/or photocopied by officials of the Food and Drug Administration or other federal or state government agencies during the ordinary course of carrying out their functions. If I participate in a sponsored research project, a representative of the sponsor may inspect my research records.
11. The data placed in the database will be stored in locked file cabinets and password-protected computers to which only the investigators, research team members and clinic directors will have access. In addition, the information gathered may be made available to other investigators with whom the investigator collaborates in future research and who agree to sign a confidentiality agreement. If such collaboration occurs, the data will be released without any personally identifying information so that I cannot be identified, and the use of the data will be supervised by the investigators. The data will be maintained in a secure manner for an indefinite period of time for research purposes. After the completion of the project, the data will be destroyed.
12. I understand I will receive no compensation, financial or otherwise, for participating in study.
13. I understand that the investigators are willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact Dr. Kathleen Eldridge at (310) 506-8559, Dr. Mesha Ellis at (310) 568-5768, or Dr. Susan Hall at (310) 506-8556 if I have other questions or concerns about this research. If I have questions about my rights as a research participant, I understand that I can contact the Chairperson of the Graduate and Professional Schools IRB, Pepperdine University at (310) 568-5600.
14. I will be informed of any significant new findings developed during the course of my participation in this research which may have a bearing on my willingness to continue in the study.
15. I understand to my satisfaction the information regarding participation in the research project. All my questions have been answered to my satisfaction. I have received a copy of this informed consent form which I have read and understand. I hereby consent to participate in the research described above.

Participant's signature

Date

Participant's name (printed)

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

Researcher/Assistant signature

Date

Researcher/Assistant name (printed)

APPENDIX H

Researcher Confidentiality Statement

As a research coder appointed by Susan Hall, J.D., Ph.D., I understand that I am expected to abide by specific principles and responsibilities to ensure effective and proper participation in the research.

I understand that coders must be sensitive to working with highly confidential material and act with appropriate discretion. Although participant numbers are used as the only method of subject identification, coders may hear names or other identifying information during the course of observing videotapes. I understand that I am prohibited from discussing any information seen or heard in the videotapes or audiotapes except with other coders and researchers involved with the study. In addition, I will only speak to research staff about information on the videotapes in a confidential environment and never in a public location. I will limit such disclosures to the minimum information that is necessary and sufficient for the purposes of communication. I also understand that coders may not discuss participant-related or other confidential material even after their involvement with the research is complete. I will also not remove any material related to the study from the office(s) of Dr. Hall or the Pepperdine Applied Research Center. In the highly unlikely event that I recognize one or more people on a videotape, I will stop the videotape immediately and inform Dr. Hall.

I will commit to _____ hours per week (to be specified by Dr. Hall) and attend all relevant coding meetings. First, I will learn a coding system so that I can use it reliably. Then, I will observe tapes and code them for research purposes. Due to the intensity of training, I agree to remain a coder on the research project for _____ months (to be specified by Dr. Hall).

I have been appointed by Susan Hall, J.D., Ph.D., to code videotaped and/or audiotaped material related to research at Pepperdine University, Graduate School of Education and psychology. The expectations of this position have been explained to me by Dr. Hall or a research assistant working with her. I understand the expectations outlined above, and agree to abide by them.

Coder Signature _____

Date _____

Witness Signature _____

Date: _____

APPENDIX I
IRB Approval Letter

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

September 2, 2010

Renee Sloane
1400 Kellen Ave #111

Protocol #: P0810D07

Project Title: **Examining Trainee Therapists' Use of Calhoun and Tedeschi's Recommended Counseling Strategies for Facilitating Posttraumatic Growth in Psychotherapy: A Qualitative Analysis**

Dear Ms. Sloane:

Thank you for submitting your application, *Examining Trainee Therapists' Use of Calhoun and Tedeschi's Recommended Counseling Strategies for Facilitating Posttraumatic Growth in Psychotherapy: A Qualitative Analysis*, for exempt review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your faculty advisor, Dr. Susan Hall, have done on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations (45 CFR 46 - <http://www.nihtraining.com/ohsrsite/guidelines/45cfr46.html>) that govern the protections of human subjects. Specifically, section 45 CFR 46.101(b)(4) states:

(b) Unless otherwise required by Department or Agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:

Category (4) of 45 CFR 46.101, research, involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit a **Request for Modification Form** to the GPS IRB. Because your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the GPS IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to "policy material" at <http://www.pepperdine.edu/irb/graduate/>).

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