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Student therapists' use of self-disclosure with clients who have experienced trauma

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STUDENT THERAPISTS' USE OF SELF-DISCLOSURE WITH CLIENTS WHO

HAVE EXPERIENCED TRAUMA

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Krista Kircanski, M.A.

July, 2014

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

This clinical dissertation, written by

Krista Kircanski

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

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

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

Edward Shafranske, Ph.D., ABPP

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ACKNOWLEDGEMENTS

VITA

KRISTA KIRCANSKI, M.A.

EDUCATION

Pepperdine University   Psy.D. (Clinical)   Expected May 2015

- Dissertation title: "Student therapists' use of self-disclosure with clients who have experienced trauma"
- Dissertation committee: Susan Hall, J.D., Ph.D., John Briere, Ph.D., & Edward Shafranske, Ph.D., ABPP

Boston University   M.A.   May 2008
                                    Psychology (Clinical)

Boston University   B.A.   May 2007
                                    Psychology
                                    Minor: Sociology

CLINICAL EXPERIENCE

Predoctoral Intern   July 2014 -
Terry Children's Center   Present
Supervisors: Diane McGuffin, Psy.D. & Thomas Olsen, Ph.D.
- Conduct intakes and provide individual, family, and group psychotherapy (e.g., TFCBT, PCIT) to children (5-13) in the Day Program and Residential Treatment Center settings
- Provide group therapy to children and adolescents (5-18) in the Crisis Stabilization Unit and provide ongoing crisis intervention with children in the CSU, DP, and RTC settings
- Provide individual and group therapy and ongoing assessments to adjudicated male adolescents (13-19) within a state detention center (Ferris School for Boys)
- Attend weekly didactic trainings, with expected certification in TF-CBT and PCIT by June 2015
- Provide extensive case management and facilitate treatment team meetings with foster parents, DFS workers, courts, psychiatry, nursing, and floor staff

Psychology Extern and Diagnostic Interviewer   April 2013 -
University of California - Los Angeles   May 2014
Semel Institute for Neuroscience and Human Behavior
Child Anxiety Disorders, OCD and Tic Disorders Program
Supervisors: John Piacentini, Ph.D., Susanna Chang, Ph.D. & Tara Peris, Ph.D.
- Conducted semi-structured diagnostic interviewing and administer assessment measures to children and families as an Independent Evaluator (IE) for 4-6 UCLA Child Anxiety Program clinical research trials
- Proficiency in administering the ADIS, KSADS, PARS, CY-BOCS, CGI-S, and CGAS 2x weekly
- Received certification as an IE from Columbia University and John's Hopkins University in the multi-site Child and Adolescent Anxiety Multimodal Extended Long-Term Study (CAMELS), a longitudinal nationwide clinical research grant examining lifetime anxiety disorders and follow-up to CAMS
- Proficiency in administering the ADIS, PARS, HONOS, CGI-S, and CGAS 3-4x monthly
- Attended weekly supervision to review assessments and match diagnoses and severity ratings

Psychology Extern   June 2012 -
University of California - Los Angeles   May 2014
Semel Institute for Neuroscience and Human Behavior
Child Anxiety Disorders, OCD and Tic Disorders Intensive Outpatient Program
Supervisor: R. Lindsey Bergman, Ph.D.

- Participated in a multidisciplinary team setting in an Intensive Outpatient Program for children/adolescents ages 7-17 with primary anxiety disorder and co-morbid diagnoses
- Provided exposure and response prevention (ERP) 6 hours/week in individual and group settings
- Participated and engaged in group didactics and Mindfulness exercises
- Assisted with exposure planning and meet with parents daily to discuss progress
- Responded to crisis intervention issues and assist in safety planning

Psychology Extern   August 2013 -
Star View Adolescent Residential Treatment Center   May 2014
Supervisors: Nicole Klasey, Psy.D. & Kate McGregor, Psy.D.

- Provided individual and group psychotherapy to adolescents housed in a locked level-14 residential Community Treatment Facility (CTF)
- Conducted comprehensive psychological testing with adolescents housed in a locked residential Psychiatric Health Facility (PHF), an acute psychiatric hospital
- Facilitated and co-facilitate groups within the Day Treatment Intensive Program (DTI)
- Performed intakes and crisis intervention with suicidal and aggressive adolescents as needed
- Attended individual and group supervision for assessment and intervention activities
- Coordinated with a multi-disciplinary team of MD's, social workers, case managers, teachers, and mental health professionals to ensure proper levels of care for patient caseload
- Case management, including coordination with families, schools, social workers, attorneys, probation officers, and the California juvenile court system
- Completed 30 hours of Professional Assault Crisis Training (Pro-ACT)

Psychology Extern   Sept 2012 -
Harbor-UCLA Medical Center   August 2013
Child and Adolescent Trauma Rotation
Supervisor: Janine Shelby, Ph.D.

- Performed intake evaluations and crisis management within the Trauma Clinic
- Provided individual and family cognitive-behavioral therapy to children and adolescents who have experienced trauma (TF-CBT)
- Provided behavioral and family therapy to traumatized children and parents (PCIT, non-directive play therapy, parent training)
- Administered and scored trauma-specific assessment measures (e.g., TSCC, UCLA PTSD Reaction Index) over patient's course of treatment to obtain outcome data
- Responded to Consultation-Liason services within the pediatric hospital setting for children, adolescents, and families who have experienced traumatic events
- Participated in a hospital-wide Psychological First Aid (PFA) drill, by providing crisis intervention and liason services to individuals following a mock disaster drill
- Attended multi-disciplinary individual and group supervision weekly to discuss cases and assist in treatment planning and intervention implementation
- Attended weekly didactic trainings on evidence-based practices (e.g., TF-CBT, PCIT, DBT, ACT)

Psychology Extern   May 2011 -
Pepperdine University Counseling Center   August 2013
Supervisors: Aaron Aviera, Ph.D. & Edward Shafranske, Ph.D., ABPP
- Performed intake evaluations and implement crisis interventions with clients in acute distress
- Provided long-term individual psychotherapy in a sliding-scale university clinic serving individuals with a wide range of Axis I and Axis II diagnoses (e.g., CBT for depression, exposure therapy, Mindfulness, relaxation training)
- Presented case conceptualizations and review videotaped sessions in a group supervision setting, to get feedback from clinical supervisor and advanced doctoral students
- Administered, scored, and interpreted intake, mid-treatment, and outcome measures (e.g., OQ, BDI, BAI)
- Maintained clinical documentation and audit client charts as needed

Psychology Fellow   Sept 2012 -
Union Rescue Mission   August 2012
Supervisors: Aaron Aviera, Ph.D. & Stephen Strack, Ph.D.
- Performed intake evaluations
- Provided individual, group, and family psychotherapy to dual diagnosis homeless individuals with severe and chronic Axis I and Axis II disorders (e.g., Motivational Interviewing, CBT for substance use, relapse prevention, harm reduction, problem solving, psychoeducational groups)
- Administered and scored cognitive and projective assessments to assist with differential diagnosis and conceptualization (e.g., WAIS-IV, Rorschach, MCMI-III)
- Maintained client charts and records
- Educated staff members with psycho-education regarding recognition and response to individuals with severe mental illness
- Attended pertinent didactic trainings and seminars that are unique to the population served
- Presented case conceptualizations, with a particular focus on differential diagnosis skills and treatment planning

Psychology Extern   Sept 2011 -
Bienvenidos Children's Center   July 2012
Supervisor: Bruce Rush, Psy.D. & Janet Urquizu, Psy.D.
- Completed Department of Mental Health (DMH) paperwork training
- Performed intake evaluations
- Provided individual and family therapy, play therapy and psychotherapy (e.g., CBT, parent training) in a DMH funded facility serving children and adolescents with government-funded insurance
- Provided assessment and individual therapy to trauma survivors though the Victims of Crime (VOC) program
- Administered/scored psychological assessments in order to clarify diagnoses, test for learning disabilities, and determine cognitive and emotional functioning
- Case management and coordination with Department of Children and Family Services, family court, foster parents, psychiatrists, and primary care doctors
- Attended weekly individual and group supervision for caseload within the general clinic and for VOC clients

Community Residence Counselor 2008 - 2009
McLean Hospital Southeast
Adolescent Acute Residential Treatment Program
- Provided general counseling services to adolescents ages 12-18 at an inpatient step-down facility following a dialectical-behavioral (DBT) model of treatment
- Provided emotional support in times of acute distress and 15-minute checks
- Developed and led a weekly recovery group promoting emotional, psychological, and physical wellness
- Assisted patients with problem solving skills and completion of behavioral chains
- Led and co-led daily groups (e.g., morning and evening check-in, mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness)

Parental Stress Hotline Volunteer, Parents Helping Parents 2007
- Answered calls weekly from parents experiencing acute distress related to their children
- Used mirroring techniques, non-judgmental statements, and provided adjunctive resources to enable parents to reach appropriate solutions on their own
- Completed ten hours of crisis intervention training

PROFESSIONAL EXPERIENCE

Administrative Coordinator of Clinical Services in Child and Adolescent Psychiatry 2009 -
Administrative Coordinator of the Child Psychiatry Psychology Training Program 2010
Project Coordinator, Massachusetts Child Psychiatry Education Program
Boston Medical Center, Department of Child and Adolescent Psychiatry
- Principal contact for families, healthcare professionals, and referrals to the child and adolescent psychiatry clinic serving low-income and underserved populations in a university teaching hospital
- Assisted with the orientation training and daily activities for interns in a psychology training program
- Helped coordinate a multi-site informational training for DCF caseworkers and managers, providing psycho-education on psychiatric practices and psychotropic medications
- Served as the point of contact for the Consultation-Liason Service
- Attended grand rounds, multidisciplinary team meetings, and clinical case conferences

RESEARCH EXPERIENCE

Research Coordinator 2011 - 2014
Pepperdine Applied Research Center (PARC)
- Created de-identified research files using closed files from the Pepperdine University Counseling Center and Irvine Community Counseling Center
- Co-supervised 7 Research Assistants who entered research data into SPSS and Excel databases and led monthly research-related meetings
- Attended bi-weekly lab meetings to provide and receive feedback during the research collection and dissertation process

Research Assistant 2008
Cambridge Hospital
- Assisted with SPSS data entry of SCID reports on a multi-site study examining alternative assessment and categorization of personality disorders.

Research on Attitudes towards Governmental Aggression   2006 - 2008
Boston University
- Developed and implemented a study based on the Personal and Institutional Rights to Aggression Survey (PAIRTAS), examining attitudes and reactions to the right to torture post-September 11th
- Using qualitative data, developed a coding manual based on Albert Bandura's Theory of Moral Disengagement and coded responses in SPSS
- Presented findings in a poster presentation at the EPA annual conference in 2007

SUPERVISION OF OTHER STUDENTS

Peer Supervisor   Sept 2013 -
Pepperdine University   Present
- Provide weekly hour-long individual supervision to 1st, 2nd, and 3rd year doctoral students who are primarily placed at the Union Rescue Mission and West Los Angeles Clinic
- Attend weekly case conferences to review videotaped sessions and provide feedback to students
- Attend weekly supervision for peer supervision, to discuss 1st, 2nd and 3rd year doctoral students' caseload, evaluate their clinical competencies, and provide feedback on progress
- Review students' intakes and provide verbal and written feedback to improve intake-writing skills
- Participate in students' mid-year and final evaluations by providing clinical and interpersonal feedback about their performance

Peer Assessment Supervisor   May 2013 –
Pepperdine University   Present

- Review administration, scoring, and interpretation of fully integrated assessment batteries (e.g., cognitive, emotional, projective) performed by 2nd and 3rd year doctoral students
- Attended weekly supervision to review cases and progress of testing reports

TEACHING EXPERIENCE

Teaching Assistant, 2nd year doctoral level course   2012 - 2013
Psychology 713: Advanced Psychological Assessment
Supervisor: Carolyn Keatinge, Ph.D.
- Preparation of class materials for assessment supervisor
- Graded papers, tests, and student scoring of personality assessment batteries (MMPI-2, MCMI-III, TAT, Rorschach, HTP, RISB) and cognitive assessment measures (WAIS-IV, WRAT, RAVLT, COWAT, TMT, MMSE)
- Provided written feedback for improved accuracy of scoring and interpretive proficiency
- Provided individual tutoring of course content for students requiring additional academic support
- Provided faculty instructors with feedback on second-year students' performances

Teaching Assistant, 1st year doctoral level course   2011 - 2013
Psychology 711: Emotional Assessment
Supervisors: Carolyn Keatinge, Ph.D., Susan Himelstein, Ph.D., Sepida Sazgar, Psy.D.
- Preparation of class materials for assessment supervisors
- Engaged in lab administrations of the Rorschach with first-year students enrolled in a clinical psychology doctoral program

- Graded papers, tests, and student scoring of personality assessment batteries (MMPI-2, MCMI-III, TAT, Rorschach, HTP, RISB)
- Provided individual tutoring of course content for students requiring additional academic support
- Provided faculty instructors with feedback on first-year students' performances

Teaching Assistant, Master's level course   2011 - 2013
Psychology 602: Emotional Assessment
Supervisors: Carolyn Keatinge, Ph.D., Susan Himelstein, Ph.D., Sepida Sazgar, Psy.D.
- Preparation of class materials for assessment supervisors
- Graded papers, tests, and student scoring of personality assessment batteries (MMPI-2, Rorschach) and provide written feedback on midterm and final examinations

Teaching Assistant, 1st year doctoral level course   2011 - 2013
Psychology 710: Cognitive and Neuropsychological Assessment
Supervisors: Carolyn Keatinge, Ph.D., Susan Himelstein, Ph.D., Sepida Sazgar, Psy.D.
- Preparation of class materials for assessment supervisors
- Engaged in lab administrations of the WISC-IV and WAIS-IV with first-year students enrolled in a clinical psychology doctoral program
- Graded papers, tests, and student scoring of cognitive assessment batteries (MMPI-2, MCMI-III, TAT, Rorschach, HTP, RISB)
- Provided individual tutoring of course content for students requiring additional academic support
- Provided faculty instructors with feedback on first-year students' performances

Teaching Assistant, Master's level course   2011
Psychology 602: Cognitive Assessment
Supervisor: Linda Nelson, Ph.D.
- Prepared class materials, demonstrated role-plays, administered labs, and created scripts for the WISC-IV and WAIS-IV tests of intelligence
- Prepared and scored students' midterm and final examinations

PUBLICATIONS

Walter, H.J., Hernandez, P.H., & **Kircanski, K.** Oppositional Defiant Disorder (2011). In Augustyn, M., Zuckerman, B., & Coronna, E.B. (Eds.), *The Zuckerman Parker Handbook of Developmental and Behavioral Pediatrics for Primary Care - Third Edition* (pp. 285-287). Philadelphia: Wolters Kluwer.

PRESENTATIONS

Kircanski, K., Cho, J., & Malley-Morrison, K. (2007, March). Moral Disengagement as Applied to Attitudes toward Torture and Killing. Poster presented at the Eastern Psychological Association (EPA) annual conference, Philadelphia, PA

WEB-BASED TRAININGS

2012   **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)**
                Medical University of South Carolina
                - Certificate of completion for 10 hours of web-based TF-CBT training

2012	**Parent-Child Interaction Therapy (PCIT)**
	University of California - Davis
	▪ Certificate of completion for 10 hours of web-based PCIT training

| 2012 | **Psychological First Aid (PFA)** |
| | The National Child Traumatic Stress Network |

SEMINARS AND TRAININGS

| 2013 | Trauma Informed Care - Attachment, Regulation, and Competency (ARC) |
| | Dana Wyss, LMFT, ATR, Starview Adolescent Center |

| 2013 | Non-Directive Play Therapy |
| | Dr. Janine Shelby, Ph.D., Harbor-UCLA Medical Center |

| 2012 - 2013 | Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) – yearlong didactic |
| | Dr. Janine Shelby, Ph.D., Harbor-UCLA Medical Center |

| 2012 - 2013 | Parent Child Interaction Therapy (PCIT) – yearlong didactic |
| | Dr. Melissa Jinariu, Psy.D. & Dr. Lauren Maltby, Ph.D., University of California – Davis |

| 2011 | Cultural and Social Perspectives on Substance Abuse/Homelessness in the African American Community |
| | Dr. Daryl Rowe, Ph.D., Pepperdine University |

| 2011 | Addressing Religious and Spiritual Issues in Therapy |
| | Dr. Edward Shafranske, Ph.D., ABPP, Pepperdine University |

| 2010 | Drugs and Drug Abuse in Los Angeles' Skid Row Community |
| | Dr. Neva Chaupette, Psy.D. |

| 2010 | Providing Psychological Services to Homeless Persons who are African American |
| | Dr. Lisa Bolden, Psy.D. |

| 2010 | Motivational Interviewing in Multicultural Settings |
| | Robert Scholz, LMFT, Pepperdine University |

| 2010 | Providing Psychological Services to Homeless Persons who are Hispanic/Latino |
| | Dr. Miguel Gallardo, Psy.D., Pepperdine University |

ABSTRACT

Therapist self-disclosure is a controversial topic in that it has been historically and widely debated in past research and literature across theoretical orientations. Much of the existing self-disclosure research focuses on the effects that therapist self-disclosure has on the therapeutic relationship, using varied methodology in its definition and measurement of how, when, and in what context therapist self-disclosure is utilized. There are also very few studies that investigate frequency rates of therapist self-disclosure; of those that do exist, results are mixed. Additionally, there is little to no research on how self-disclosure is used by student therapists, in actual psychotherapy sessions, particularly in the context of sessions in which difficult or traumatic subject matter is discussed.

Accordingly, the purpose of the present study was to qualitatively explore verbalizations of student therapist self-disclosure in psychotherapy sessions with trauma survivors. A sample of 5 therapist-participants from university-based community counseling centers were selected, and transcribed videotaped sessions in which client- and therapist-participants discussed trauma were analyzed. A qualitative and deductive content analysis was employed, using a coding system that was created based on the extant literature on therapist self-disclosure, to examine verbal expressions of therapist self-disclosure in psychotherapy sessions with trauma survivors. The results indicated that the therapist-participants used many different forms of self-disclosure (self-involving disclosures, disclosures that are not otherwise specified, personal self-disclosure, and demographic self-disclosures, in order of frequency) both within and out of trauma discussions. More specifically, self-involving disclosures (SINV-PERS) tended to occur

more frequently within trauma discussions while personal and demographic disclosures (SDIS-PERS and SDIS-DEMO) tended to occur more frequently in non-trauma discussions. Therapist self-disclosures comprised 6 of the 9 proposed coding categories over all 5 psychotherapy sessions.

It is hoped that this study will raise awareness around the issue of the use of therapist self-disclosure in psychotherapy, both in general and with clients who have experienced traumatic events during the course of their lives. The findings have implications for both future studies examining therapist self-disclosure as well as clinical training practices in graduate programs for student therapists, an area of study that is currently under-researched.

Chapter I. Literature Review

Many individuals experience traumatic events over the course of their lives, and develop ways in which they respond to or cope with these disturbing events. The positive psychology movement emphasizes adaptation and resilience to trauma, which leads those who have experienced trauma to recovery and growth following such devastating events (Seligman & Csikszentmihalyi, 2000). While some people seek psychotherapy related directly to the trauma, or present to therapy for unrelated symptoms, others never receive treatment at all. Various forms of psychotherapy can assist traumatized individuals to experience symptom and distress reduction as well as develop an increased sense of growth and recovery post-trauma.

Therapist self-disclosure, a controversial topic that has long been the subject of debate across various theoretical orientations, involves therapists bringing a part of themselves into the therapy session, either by disclosing facts about themselves or countertransference reactions about the client. In the literature on self-disclosure in psychotherapy, there are very few studies that utilize actual therapy sessions as a basis for comparison (e.g., Myers & Hayes, 2006); rather, many use analogue research methods in which raters code scripts or mock therapy sessions with actors (e.g., Bridges, 2001; Yeh & Hayes, 2011). Additionally, only one recent study could be found that examined the use of self-disclosure by therapists in training (Bottrill, Pistrang, Barker, & Worrell, 2010).

Given that one study found approximately one-third of therapists who provide treatment to individuals who have been traumatized have experienced a trauma themselves, and over 90% of therapists self-disclose, more research examining how

therapists' trauma histories/experiences impacts therapists' behaviors in treatment is warranted (Henretty & Levitt, 2010; Pope & Feldman-Summers, 1992). There has been some research that has examined the use of therapist self-disclosure with trauma survivors of which the results are mixed; however, no studies appear to examine actual therapy sessions with student therapists (LaPorte, Sweifach, & Linzer, 2010).

Thus, there appears to be a paucity of research and literature that examines the variables of therapist self-disclosure, trauma treatment, and developing therapists-in-training. This study proposes to involve a qualitative analysis of expressions of therapist self-disclosure with university clinic-based adult psychotherapy clients who have experienced trauma. First, the literature review begins with a discussion of positive psychology and its relationship to trauma, including the definition, trajectories and types of trauma. Next, a background of therapist self-disclosure is presented chronologically and through the filter of various theoretical orientations. The chapter then describes both the definition and types of therapist self-disclosure evident in the present literature. Finally, this chapter ends with a discussion of the relationship between therapist self-disclosure and the therapeutic relationship, specifically in trauma treatment.

Trauma from a Positive Psychology Perspective

It has been suggested that traditional theories of pathology and mental illness as related to trauma underestimates and does not fully account for an individual's ability to not only maintain psychological and physical integrity in the face of trauma, but also to grow from it (Linley & Joseph, 2005b). In fact, numerous events for which growth outcomes have been observed include: transportation accidents (plane crashes, car accidents), natural disasters (earthquakes, tsunamis), interpersonal experiences (rape,

combat, domestic violence, mass shootings), medical injuries and problems (cancer, HIV/AIDS), and other life experiences (bereavement, divorce, immigration; Joseph, 2005; Linley & Joseph, 2004). Furthermore, vicarious experiences of posttraumatic growth have been demonstrated in populations who did not experience the suffering themselves; these group comprise counselors, psychologists, funeral directors and disaster workers, to name a few (Linley & Joseph, 2005a, 2006, 2007). Currently, the majority of this research has been done with adults, but there is a growing awareness that children may also display this same sort of growth and resilience (Joseph, 2009). This dissertation focuses on adults' experience of and reaction to traumatic events.

The purpose of this section is to provide a balanced description of trauma, informed by the emerging field of positive psychology. To accomplish this goal, it begins with a brief introduction to positive psychology, the background perspective that informs this study, as well as a discussion of trauma as viewed through the lens of positive psychology. Next, traumatic events are discussed, followed by an explanation of the different trajectories of trauma, including both positive and negative. Finally, the section examines the process of trauma disclosure and discussion, more specifically in mental health settings, including the various ways in which therapists may elicit and respond to the discussion of trauma in psychotherapy.

Positive psychology. Although the use of positive psychology as a term is relatively recent, it is a field that builds upon earlier schools of thought and perspectives in the field of psychology that focus on areas including: meaning making, positive human characteristics, resilience and giftedness (Allport, 1958; Audet & Everall, 2010; Gable & Haidt, 2005; Jung, 1933; Maslow, 1968). Positive psychology emerged as a result of a

perceived imbalance between positive and negative that seemed to exist in the field of psychology, with the majority of research and literature focusing on pathology and mental illness (Gable & Haidt, 2005). As a result of this disparity, Seligman and other positive psychologists who theorize, research, and clinically practice from this strength-based approach set out to identify different constructs (e.g., faith, gratitude, optimism, resilience, positive emotions, humor) in people and psychotherapy clients that could be reinforced and strengthened in order to ward against mental illness (Seligman & Csikszentmihalyi, 2000). Using this approach, negatives are acknowledged and repaired and positives are bolstered, resulting in a more complete understanding of human experience.

According to Seligman and Csikszentmihalyi (2000), positive psychology aims to highlight strengths not only on an individual level, but also in groups and institutions. In these domains, it encourages not only survival and endurance of some of the more difficult life challenges that people face, but also the ability to flourish despite these obstacles (Gable & Haidt, 2005). Thus, the theory of positive psychology is built on three pillars, which include: positive subjective experience, positive individual characteristics (i.e., virtues and strengths) and positive communities and institutions. Friedman and Robbins (2012) state that of these three pillars, much of what we know about positive psychology focuses solely on virtues and isolated traits that have been theoretically derived. Positive psychology as it is related to clinical and trauma populations shows preliminary promise and is an area for growth in the field.

Positive psychology has been used in clinical settings as a part of assessment and treatment, and has been shown to be efficacious in reducing symptoms of

psychopathology (Briere & Scott, 2006; Lambert & Erekson, 2008; Seligman & Csikszentmihalyi, 2000, Seligman, Rashid, & Parks, 2006). More recently, attention has been given to adopting measures that assess dimensions of positive functioning in addition to the traditional measures of negative or maladaptive functioning (e.g., from depression to happiness, from relaxation to anxiety; Joseph & Wood, 2010). Positive psychotherapy (PPT), or the implementation of positive psychology interventions with clinical samples, includes behaviorally based exercises that highlight individuals' personal strengths (e.g., humor) rather than focus on their deficits. For example, a recent meta-analysis of 51 positive psychology interventions (PPIs) demonstrated effectiveness in enhancing well-being and ameliorating depressive symptoms in both depressed and non-depressed participants (Sin & Lyubomirsky, 2009). Also, a pilot study by Meyer, Johnson, Parks, Iwanski, and Penn (2012) found that 16 individuals diagnosed with schizophrenia who were exposed to group positive psychotherapy (PPT) displayed improvements in psychological well-being, including increased hope, savoring, psychological recovery, self-esteem, and paranoid, psychotic, and depressive symptoms at 3-month follow-up that were possibly due to the group intervention, but may have been attributed to other unrelated factors as well (Meyer et al., 2012). More comprehensive research in positive psychology assessment and treatment is warranted.

Despite its utility, there are several criticisms of the field and limitations that have been noted. Some have argued that positive psychology fails to adequately explore the negative aspects of life, which may reflect an overly positive or "Pollyanna" view of the world (Held, 2004; Lazarus, 2003). Miller (2008) also argues that positive psychology is based on flawed arguments and the belief that "people who are by nature optimistic,

amiable and untroubled by worries or doubts are happiest" (p. 605), which could be seen as too simplistic in nature. In response to such critiques, Gable and Haidt (2005) argue that the goal of positive psychology is not to erase work involving dysfunction or psychopathology, but instead to maintain a foundation of human growth, strength, and resilience despite such negative aspects of life. Additionally, researchers have pointed out the importance of refraining from a "one-size-fits-all" (Norem & Chang, 2002, p. 993) approach to improving human functioning, by remaining open to new and different approaches

Additionally, researchers have pointed out that positive psychology needs to take into account individual differences when providing positive psychology interventions. For example, Meyer et al. (2012) found that self-critical individuals were particularly responsive to positive psychology interventions while needy individuals found the exercises ineffective and even detrimental to their self-esteem. Additionally, it has been suggested that depressed and anxious individuals have developed effective strategies for dealing with their feelings, and that restraint should be taken to "make [them] into optimists" (Azar, 2011, p. 32). Other individuals have posited that within the field of positive psychology, too much focus is placed on the individual, while little emphasis is placed on positive societies, situations, cultures, and institutions (Christopher & Hickinbottom, 2008; Diener, 2009).

Lazarus (2003) further critiqued the field of positive psychology, arguing that there were major conceptual and methodological limitations present. These included: (a) the cross-sectional nature of much of the research does not allow causal claims to be supported, (b) much of the terminology focuses on "positive" and "negative" which may

be an oversimplification of constructs, (c) research doesn't focus enough on differences between individuals, and (d) the use of questionnaires and checklists to assess complex emotional states may not be valid approaches (Lazarus, 2003). Csikszentmihalyi (2003) argues that these limitations are present in psychological research as a whole, and asserts that Lazarus may be "blaming positive psychology for not being better than the rest of the profession" (p. 114).

Lastly, some have argued that positive psychology does not operate from a multicultural framework, tends to operate from a Western perspective, is aimed at individualistic cultures, and is overall ethnocentric in its nature (Christopher & Hickinbottom, 2008; Kubokawa & Ottaway, 2009; Leu, Wang, & Koo, 2011; Lopez et al., 2005). Such assertions have challenged positive psychologists to integrate multicultural practices into their work with diverse client populations.

Trauma from a positive psychology perspective. Taking into account both positive and negative aspects of human functioning, Joseph, Linley, and Harris (2005) proposed that one can better understand the process of trauma, and thus develop appropriate therapeutic interventions for trauma, when this process of growth, resilience and change occurs and is examined at a micro level. Using such a micro lens, as noted above, the following subsections focus on the various types of traumatic events, positive and negative posttraumatic trajectories, and prevalence rates of trauma. Next, a discussion of trauma disclosure is presented, including possible reactions to trauma disclosures, which can also be categorized as positive or negative, depending on the action or reaction of the recipient.

Traumatic Events

As presented in the following sections, there are a multitude of events that can occur in an individual's life that could be considered potentially traumatic. For this reason, when some people refer to trauma, they equate it with certain events that are directly or indirectly experienced by a person; others take into account the effects that occur as a result of experiencing the traumatic event, both of which are described in the next subsection.

The term primary trauma refers to the direct experience of a traumatic situation by an individual or group of people. These precipitating events can include: war/combat exposure, domestic violence, childhood sexual abuse, transportation accidents, natural disasters, victimization, rape/sexual assault, terrorist attacks, life-threatening illness, sex trafficking, torture and emergency worker trauma exposure (Woo & Keatinge, 2008). Similarly, in Kira et al.'s (2008) two-way taxonomical model of trauma types, one of the classifications is based on the objective characteristics of such events. It includes a broad ranges of "objective" traumatic events, including: cumulative stress trauma (i.e., prolonged, repeated traumas that have the potential to elicit symptoms); internal trauma (e.g., traumatic pain and severe medical conditions); nature-made (e.g., earthquakes, hurricanes, tsunamis); and man-made traumas (e.g., extreme poverty, car accident, and complex traumas; Kira et al., 2008). Complex traumas can include both repeated similar traumatic events that eventually ceased (e.g., childhood sexual and physical abuse) and those that are repeated and ongoing (e.g., racism and discrimination). Complex traumas involve a series of similar and dissimilar traumas, including any of the aforementioned types, which have occurred over the individual's life span (Kira, Lewandowski, Somers,

Yoon, & Chiodo, 2012).

Secondary trauma, otherwise known as vicarious traumatization, compassion fatigue, or empathetic strain, refers to the subjective experience of trauma by a second party (e.g., friend; police officer; emergency room nurse; pastoral counselor; humanitarian worker), both as the process of a trauma discussion occurs and over time in working with trauma survivors (Elwood, Mott, Lohr, & Galovski, 2011; Figley, 1995). Treatment providers (e.g., psychologists, social workers, substance abuse counselors) also may experience secondary trauma, or develop secondary traumatization, in response to hearing individuals describe their primary traumas (Figley, 1995). This secondary traumatization may result in the development of PTSD-like symptoms and other trauma-related changes in the treatment provider (Elwood et al., 2011).

Proponents of the concept of secondary traumatization suggest that clinicians who provide PTSD-specific treatment (e.g., Trauma-Focused CBT, prolonged exposure, cognitive processing therapy) might be particularly at-risk for both exposure to secondary trauma and the experience of secondary or vicarious traumatization (Figley, 1995; Pearlman & Saakvitne, 1995). Similarly, Bride, Hatcher, and Humble (2009) found that substance abuse counselors were highly likely to be secondarily exposed to traumatic events through their work with traumatized populations; many experienced at least some symptoms of secondary traumatization, with 75% of their counselor sample experiencing at least one symptom in the past week and 19% qualifying for a diagnosis of PTSD. They further found that most substance abuse counselors were not being prepared for practice with traumatized populations in their academic curriculum, practicum training or internship experience. However, most counselors reported that they did seek out training

related to working with traumatized populations on their personal time and in continuing education courses (Bride et al., 2009). This finding has large implications for the present study, given that it examines student therapists who are providing therapy to traumatized individuals. Further research in this area is warranted.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (5th ed.; DSM-5; American Psychiatric Association, 2013), refers to both primary and secondary trauma in its definition of "traumatic events" (p. 271). This definition is part of diagnostic criterion A for Posttraumatic Stress Disorder (PTSD):

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: (a) directly witnessing the traumatic event(s); (b) witnessing, in person, the event(s) as it occurred to others; (c) learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental; and (d) experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse; note: this criterion does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related. (p. 271)

This combined definition of traumatic events appears to be widely used in the field of clinical psychology, though there has been debate about whether it (and the previous definition of PTSD as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (4th ed., text rev.; DSM-IV-TR; American Psychiatric

Association, 2000), which was initially used in the present study as the DSM-5 was not yet released) is clinically useful and accurate. Because the DSM-5 is a fairly new publication, much of the debate relates to the previous definition of PTSD as it was defined in the DSM-IV-TR. These arguments are presented next.

It has been proposed by some researchers that the definition for PTSD as previously defined by the DSM-IV-TR (APA, 2000) may not have accurately captured all aspects of traumatic events and the diagnosis itself. For example, the DSM-IV-TR's definition stated that PTSD can occur after repeated childhood sexual abuse or a single trauma threatening life or safety. Seides (2010) asserts that PTSD can occur from multiple, less severe trauma ("microtraumas," p. 725), which can be a consequence of a history of longstanding neglect, humiliation, or inaccurate attribution of blame. Like Seides (2010), Norris (1992) proposed including potentially traumatic situations of a less severe nature that may be reinforced over time; for example, violent encounters with humankind, technology, or nature. Other researchers have similarly found that PTSD can develop without an exposure that threatens life or physical integrity (Hasanoglu, 2008); rather, it can occur from a series of relatively minor emotional insults that over time build up, leading to extreme life stressors and poor coping skills. Similarly, some have studied bullying and found that the effects of long-standing aggression to one's ego and sense of self can produce the same symptoms of an individual who develops PTSD in response to a single traumatic event (Wilson, 1991).

Norris (1992) argued for a more restrictive and objective definition of trauma that was less susceptible to the responses an individual has to the potentially traumatic event. Another researcher proposed that a more restrictive definition of PTSD be limited to

individuals who directly experienced a traumatic event directly (as opposed to those who witnessed or learned about an event in which there was a threat to the physical integrity of another) might be indicated (McNally, 2004).

In their critical review of PTSD as related to the previous DSM-IV-TR (and arguably, to the newly released DSM-5), Friedman et al. (2011) questioned whether PTSD actually even belonged in the anxiety disorders category (as it appeared in DSM-IV-TR), or whether a separate grouping of "trauma and stressor-related disorders" (p. 737) should be created in the new APA manual (as it now appears in the DSM-5). Using their model, this new class of disorders includes disorders ranging in severity, such as adjustment disorders (AD), acute stress disorder (ASD), and PTSD and dissociative disorders (DD). On one hand, some researchers argued that PTSD is most closely linked with the anxiety disorders because of "the presence of alarms and the general process of anxious apprehension," including intrusive recollections of trauma and nightmares (Jones & Barlow, 1990). On the other hand, Friedman et al. (2011) point out that PTSD also presents with characteristic symptoms above that of an anxiety disorder, including numbing, alienation and detachment. As noted, PTSD is now included under the newly created Trauma- and Stressor-Related Disorders category in the DSM-5.

McNally (2009) proposed that the A1 Criterion of PTSD be modified so that indirect exposure to a traumatic event (as it appeared in the DSM-IV-TR) was eliminated for the more recently released DSM-5; he proposed that instead, individuals who experience this type of trauma be given a diagnosis of Anxiety Disorder NOS or a newly introduced V code of "acute non-pathological reactions to a stressor" (p. 598). The APA Anxiety, OCD-Spectrum, Posttraumatic, Dissociative Disorders Work Group proposed a

similar change to occur in the DSM-5, limiting a diagnosis of PTSD to only those who have: (a) directly experienced the traumatic event, (b) witnessed it in person, (c) learned that the violent or accidental death had occurred to a close friend or family member, or (d) experienced extreme or repeated exposure to aversive details of the traumatic event (e.g., first responders collecting human remains; APA, 2012). According to the DSM-IV-TR's definition of PTSD, the individuals who watched the attacks on television qualify for the label of trauma survivor in the same way as those who escaped the World Trade Center in 2001. As Young (2007) put it, we now have "PTSD of the virtual kind" (p. 21). The new Criterion A precludes those who witness the traumatic event through electronic media outlets from a diagnosis of PTSD. In addition, the APA Anxiety, OCD-Spectrum, Posttraumatic, Dissociative Disorder Work Group suggested including an additional category such a Trauma or Stress Related Disorder Not Elsewhere Classified, for trauma-related disorders that do not meet full or specific criteria for PTSD.

A critique of this stance is that in developing a particularly rigid definition of PTSD (i.e., not including those who may have watched the September 11th attacks on television), individuals who are experiencing trauma-related symptoms might not qualify for necessary mental health services. Conversely, an overly broad definition for use in research purposes could result in inclusion of participants who had much different precipitating events that led to symptoms of PTSD, making the sample too heterogeneous for comparison.

An inclusive and accurate definition of trauma must also take cultural issues into account. Scurfield and Mackey (2001) argued that the DSM-IV-TR failed to adequately include cultural considerations in regards to trauma experienced by ethnic

minorities. More specifically, the DSM-IV-TR did not reference race-related stressors and trauma (i.e., hate crimes, race-related physical or verbal abuse) and did not include the terms "racist" or "racism" throughout any of the text (Scurfield & Mackey, 2001). In fact, racial violence and oppression that have spanned generations can be considered forms of personal and shared trauma. For example, the Native American genocide, Japanese American internment, the Nazi Holocaust and the African American slavery experience are all examples of the above mentioned, prolonged oppression and abuse that was and is collectively experienced and re-experienced by current and future generations (Tummala-Nara, 2007). In fact, long-standing effects of this shared trauma can be transmitted to future generations long after the trauma has occurred, and can have a profound effect on an individual's sense of self and ability to function (Kogan, 1993). Because many ethnic minority groups are at a higher risk for experiencing trauma and violence (Walters & Simoni, 2002), the definition of trauma is highly influenced by the experience of both collective minority groups and individuals who identify as ethnic minorities.

Preliminary research has identified potential cultural formulation frameworks that may be useful for improving the diagnostic assessment of culturally diverse individuals in community settings (Fortuna, Porche, & Alegria, 2009). In fact, the new DSM-5 now includes the following information on culture-related diagnostic issues for PTSD (Hinton and Lewis-Fernández 2011):

> The risk of onset and severity of PTSD may differ across cultural groups as a result of variation in the type of traumatic exposure (e.g., genocide), the impact on disorder severity of the meaning attributed to the traumatic event (e.g., inability to

perform funerary rites after a mass killing), the ongoing sociocultural context (e.g., residing among unpunished perpetrators in post-conflict settings), and other cultural factors (e.g., acculturative stress in immigrants). (p. 272)

Thus, there have been significant difficulties in defining traumatic events accurately, given the individual differences in people and the many factors that determine whether one will develop PTSD or other significant difficulties (e.g., culture, genetics, environmental stressors, coping skills, social support). Weathers and Keane (2007) point out that when a subjective component is involved (as it was previously defined in the DSM-IV-TR), it can be very difficult to subjectively quantify what a "stressor" constitutes, as this would look very different depending who is asked. In fact, research has demonstrated that mental health professionals commonly misdiagnose PTSD in children, adolescents, and adult populations (Rosen, 1995; Sbordone & Ruff, 2010; Sumpter & McMillan, 2005). Furthermore, given that posttraumatic reactions tend to fall on a continuum, and individuals who do not meet criteria for full PTSD may be equally as impaired in functioning, it is important that mental health professionals be aware of their biases and subjectivity (Schnurr, Friedman, & Bernardy, 2002; Stein, Walker, Hazen, & Forde, 1997; Yule, Williams, & Joseph, 1999), and seek consultation if they are unsure whether an individual may be presenting with symptoms related to trauma. Weathers and Keane (2007) did, however, acknowledge that the previous DSM-IV-TR definition did allow for variation in the type, duration, proximity and intensity of the traumatic event.

Epidemiological studies have found that the rates of exposure to traumatic events in the overall population are between 60 – 80% (Solomon & Davidson, 1997). Overall,

research suggests that prevalence rates of exposure to potentially traumatic events range anywhere from 16-90% worldwide (Helzer, Robins, & McEvoy, 1987). Possible explanations for the variance in these figures include: populations included in the sample, definition of traumatic events used, and sample size. A recent study, which examined exposure to potentially traumatic events in Australia, revealed that endorsement of these events increased by 18% from 1997 to 2007 (56.9 and 74.9%; Mills et al., 2011). However, when the researchers in this study examined the variables more closely and performed cross-cohort analyses, it was found that these differences were not directly related to an increase in trauma exposure over time; rather, the increase was explained by endorsement of new, potentially traumatic events that were not included in the 1997 survey (Mills et al., 2011). This differing methodology points out the need for comprehensive surveys that examine the growing number of potentially traumatic events that could lead to the development of PTSD.

Alternatively, an argument can also be made that the expansion of the previous survey may result in the inclusion of events that are beyond what one would consider potentially traumatic. This potential finding may contribute to the large discrepancies found in prevalence rates of trauma in the current body of research. Future longitudinal studies in this area are warranted in order to determine whether the increase in endorsement of potentially traumatic events directly related to an increase in trauma exposure or whether it is due to limitations in survey methodology.

Despite the limitations that exist as a result of inconsistent definitions of traumatic events, there is an ever-growing body of research that suggests that people respond to trauma in different ways. The next section discusses both the positive and negative

trajectories that may result following trauma, and includes a summary of the current section.

Trajectories of Trauma

In the aftermath of the occurrence of a traumatic events or events, there are several distinct ways in which individuals tend to respond, which are characterized into categories known as trauma trajectories (Bonanno, 2008). Overall, the wide range of trajectories that have been identified can be further divided into positive and negative overarching categories. First the positive trajectories of trauma are introduced, including a discussion of increased ability to cope and posttraumatic growth. Next, the negative trajectories of trauma are discussed, including a proposed model for the emerging developmental functions that are negatively affected by trauma, the neurobiological changes that occur following trauma, trauma dysregulation as related to the previous DSM-IV subjective experience of trauma, and the negative effects that may result from trauma.

Positive trajectories. While the experience of trauma has historically been linked with negative outcomes, it has been demonstrated that some individuals experience constructive outcomes, which are known as positive trajectories. These include, but are not limited to: posttraumatic growth, recovery, and resilience (Tedeschi & Calhoun, 2004). Posttraumatic growth (PTG) refers to personal psychological growth following the experience of a traumatic event, with research showing increased rates of PTG among trauma survivors (Tedeschi & Calhoun, 2004). One particular study, which assessed PTG in 138 Taiwanese individuals who had physical injuries following the 2004 Southeast Asian earthquake-tsunami, found that posttraumatic growth had occurred both

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interpersonally and intrapersonally, at rates of 32% and 37%, respectively (Tang, 2007).

Additionally, recovery refers to one's ability to manage and decrease symptoms over

time, resulting in increased well-being and a return to pre-traumatic functioning

(Bonanno, 2008). Resilience is differentiated from both recovery and posttraumatic

growth in that resilient individuals who experience significant traumas display minimal

symptoms and maintain a balanced equilibrium, which helps them to cope with the events

that they experienced (Linley & Joseph, 2005a; Tedeschi & Calhoun, 2004). In fact, it

was noted approximately twenty years ago that the majority of people who have

experienced some sort of trauma actually demonstrate resilience (Lyons, 1991).

Research on positive trajectories following trauma generally supports the notion

that some trauma survivors do experience positive changes associated with PTG. A study

by Mols, Vingerhoets, Coebergh, and van de Poll-Franse (2009) found that many breast

cancer survivors experienced benefit-finding (i.e., positive outcomes to their cancer

experience) and reported higher levels of life satisfaction than before. These experiences

of PTG were positively correlated with effective and positive coping, social support,

socioeconomic factors, perceived emotional intensity of cancer, communication with

other survivors, and time since diagnosis (Mols et al., 2009). Other studies have

demonstrated that PTG in adult diagnosed with cancer and HIV/AIDS was significantly

correlated with more positive mental health and improved self-reported physical health

outcomes (Sawyer, Ayers, & Field, 2010). In this study, those who reported PTG tended

to be younger adults and of non-white ethnic origin, suggesting that PTG is demonstrated

in homogeneous samples.

However, given that research in positive trajectories is fairly new and few longitudinal studies, if any, have been conducted, further research is warranted with diverse populations who have experienced a variety of traumatic events. Overall, preliminary evidence suggests that although traumatic events have been historically associated with a negative outcome and decreased inability to cope, there is reason to believe that these experiences can actually lead to growth and utilization of internal and external resources and many individuals who experience trauma also demonstrate resilience.

Negative trajectories. Following the experience of a traumatic event or series of events, some individuals suffer from both short- and long-term consequences that are directly related to the trauma, also known as a negative trajectory. Examples of these trajectories include, but are not limited to: a potentially chronic disruption in functioning, a delayed onset of dysregulation with increased dysfunction over time, and a period of recovery which involved a decrease in dysregulation over time after one experiences a significant trauma but with significant negative effects (Bonanno, 2008). The nature of such dysfunction has been described in various ways. This subsection describes a proposed model of trauma based on negative developmental trajectories of trauma, neurobiological changes that occur following trauma, and trauma dysregulation as related to the previous DSM-IV-TR criteria of the subjective experience of trauma within PTSD.

First, Kira et al.'s (2008) two-way taxonomical model of trauma types proposes that traumatic stressors be alternatively categorized according to the emerging developmental functions negatively affected by trauma (not merely the traumatic event types previously discussed). These functions include: attachment (e.g., parental

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abandonment); individuation/identity and personal (e.g., incest, rape and/or sexual and physical abuse); collective (e.g., targeted genocide, slavery, discrimination); self-actualization or role identity (e.g., failed business, loss of savings); physical identity or physical survival (e.g., life threatening accident); and interdependence, indirect, shared or secondary trauma (e.g., witnessing violence or violence exposure through media; although this latter function appears to be a trauma type; Kira et al., 2012).

Second, exposure to early traumatic life events has been found to be associated with specific neurobiological changes and differences in neurotransmitter levels (Heim & Nemeroff, 2001). For example, Heim and Nemeroff (2001) founds that there were lower amounts of adrenocorticotropic hormone found in women who had a history of abuse stemming back to childhood when compared to women with no history of abuse. Similarly, their research revealed that a history of childhood maltreatment in individuals (i.e., physical, sexual, or emotional abuse or neglect) is correlated with hyperactivity in corticotrophin-releasing factor neurotransmission as well as in other neurotransmitter systems, resulting in increased sensitivity and stress response. In a different study, researchers found that individuals who were diagnosed with PTSD and had a positive history of trauma, exhibited lower adrenocorticotrophic hormone responsiveness than those that were in the comparison control group, and substance dependence rates were nearly 50% greater than that of individuals who did not experience childhood trauma (Santa Ana et al., 2006).

Third, and most commonly, trauma dysregulation is equated with the DSM-IV-TR criteria for Posttraumatic Stress Disorder (PTSD) describing the personal/subjective effects of experiencing or witnessing a Criterion A traumatic event. Therefore, there is

both a subjective and objective (described previously) component to PTSD. When discussing trauma, it is important to take into account this level of psychological stress that the person is experiencing, meaning the "relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (Lazarus & Folkman, 1984, p. 21). More specifically, to meet DSM-IV-TR criteria, the person needed to react with fear, helplessness or horror. Symptoms can include, but are not limited to: "recurrent and intrusive distressing recollections of the event," "intense psychological distress at exposure to internal and external cues that symbolize or resemble an aspect of the traumatic event," "efforts to avoid thoughts, feelings, or conversations associated with the trauma," "hypervigilance," and "difficulty falling or staying asleep" (American Psychiatric Association, 2000, p. 468). While it can be argued that stress is inevitably a part of everyone's life, the type of distress associated with PTSD symptoms is significant and marked, such that it disrupts normal or baseline functioning in different domains of functioning (occupational, social, academic). Of note, this criterion is no longer present in the current edition of the DSM-5.

One case study examined levels of distress with university students who had experienced a natural disaster (McCarthy & Butler, 2003). At three different times following the natural disaster, participants (students attending a university) were asked to complete the Trauma Symptom Inventory (TSI) which is commonly used to assess for PTSD. In this study, therapists who treated 18 college students (2 men, 16 women; mean age = 24; all Caucasian) who experienced a tornado initially (1-week post-tornado) had feelings of anger, anxiety and irritability (Briere, Elliott, Harris, & Cotman, 1995;

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McCarthy & Butler, 2003). However, the authors identified that client levels of anxiety and irritability declined significantly over the course of nine months post-tornado in students who participated in the study, demonstrating some evidence to suggest that the passage of time alone may serve to decrease symptoms associated with a negative trajectory.

Several meta-analyses have demonstrated that in addition to helplessness and fear, individuals who have experienced trauma and have PTSD may also experience anger, hostility and interpersonal difficulties (Orth & Weiland, 2006; Taft, Watkins, Stafford, Street, & Monson 2011). Additionally, research has demonstrated that a subset of PTSD symptoms, including numbing and dysphoria, appear to be closely related to the symptoms of other mood and anxiety disorders, specifically major depressive disorder (MDD) than other more specific PTSD symptoms, such as avoidance, intrusions, and arousal (Gros, Simms, & Acierno, 2010). In fact, Gros, Price, Magruder, and Frueh's (2012) study found that veterans in their MDD-only condition reported similar scores on PTSD symptom scales as veterans in the PTSD-only condition, demonstrating an overlap in symptoms.

Since the landmark Epidemiological Catchment Area (ECA) survey was conducted (Helzer et al.) in 1987, which measured PTSD prevalence rates across the U.S. in civilians and wounded and non-wounded Vietnam veterans, many representative general population surveys have been distributed worldwide to examine the prevalence of exposure to traumatic events that may lead to PTSD. Approximately 5% of men and 10-12% of women report receiving a diagnosis of PTSD at some point in their lives (Solomon & Davidson, 1997). Additionally, approximately 80% of individuals who are

diagnosed with PTSD suffer from other psychiatric conditions (Solomon & Davidson, 1997), which may have been present prior to the onset of PTSD or may be directly related to PTSD and exposure to a traumatic life event. According to Schlenger, Caddell, and Ebert's survey (2004), approximately 4% of people who were far from the September 11th attacks developed probable PTSD in response to watching the events unfold on television.

The likelihood and course of PTSD is significantly affected by a variety of risk factors, which include: ethnicity, gender, trauma severity, age at trauma occurrence, and life stressors and social support that occur following the trauma(s) (Brewin, Andrews, & Valentine, 2000). In a large scale meta-analysis of PTSD research, Brewin et al. (2000) found that ethnic minorities and women were at a greater risk and more susceptible for developing symptoms of PTSD. Additionally, an individual's risk increased further when the trauma was experienced at a young age and received less social support following the trauma(s). Similarly, risk further increased for those who experienced multiple and severe traumas and who displayed higher levels of subsequent life stress (Brewin et al., 2000). Though these findings were not replicated across all 77 of the studies that were included for the purpose of meta-analyses, there is preliminary evidence to suggest that multiple risk factors play a role in the development of PTSD. Also, Ozer, Best, Lipsey, and Weiss (2008) found that several variables, including prior trauma, psychological adjustment, a family history of mental health issues, perceived threat to life during the trauma, emotional responses and dissociation were particularly predictive of PTSD symptoms in their study. They highlight, in particular, the strong predictive value

of the processes that occur *during* the trauma (e.g., perceived threat to life and dissociation) in the development of PTSD.

In addition to examining PTSD, more researchers have become interested in exploring what is referred to as "complex trauma," a term which describes the effects of experiencing multiple, chronic and often prolonged traumatic events that typically are highly interpersonal and have an onset in early childhood (e.g., longstanding medical illnesses, human trafficking, domestic violence, child abuse and community violence (Cook et al., 2005; Courtois, 2008). The result of cumulative and repetitive trauma is often that of disrupted psychological, biological and social systems, and decreased functioning in later adulthood (Cook et al., 2005; Courtois, 2008).

Some have proposed new disorders, including Complex Posttraumatic Stress Disorder (CPTSD) and Developmental Trauma Disorder (DTD), which are believed to more accurately capture the disruptions in functioning that is seen in individuals who have complex trauma histories (Resick et al., 2012; van der Kolk, 2001; Williams, 2006), though more research is needed to more clearly define how complex trauma differs in presentation from PTSD (Courtois, 2008). For example, Courtois (2008) also suggested that CPTSD can occur as the result of a single catastrophic trauma, which stands in direct opposition to the current definition of CPTSD included in the former DSM-IV-TR. Thus, Resick et al. (2012) describe the lack of consistency in symptom descriptions and resulting lack of ability to define and measure CPTSD, which is thought to occur in response to more long-term, repeated traumas, such as childhood sexual abuse or domestic violence. Accordingly, Resick et al. (2012) propose that a dimensional structure for CPTSD would be consistent with current evidence from research studies that

demonstrate a small number of internalizing psychopathology dimensions can explain an array of DSM categorical diagnoses, including anxiety and mood disorders and BPD (Kotov et al., 2011; Krueger, 1999; Watson, 2005).

Preliminary studies suggest that in addition to CPTSD and DTD, childhood trauma survivors who experienced physical or sexual abuse are more likely to also meet criteria for major depression, ADHD, low self-esteem, behavioral problems in childhood, and impaired functioning in adulthood when compared with individuals with no history of trauma (Heim & Nemeroff, 2001; Reiland & Lauterbach, 2008). These results highlight the need of future research in this area. Additionally, there have been several studies that have demonstrated that pathological reactions to trauma included in PTSD have been found to be better characterized as a dimension of symptomatic severity rather than in discrete categories (Broman-Fulks et al., 2006, 2009; Forbes, Haslam, Williams, & Creamer, 2005; Ruscio, Ruscio, & Keane, 2002).

In sum, researchers have noted limitations in the present models of trauma, have argued for the inclusion of a broader range of traumatic events as well as responses and reactions to trauma, and question the cultural applicability of PTSD in different populations (Bracken, Giller, & Summerfield, 1995; Briere & Scott, 2006). Additionally, other researchers have proposed more restrictive and objective definitions of trauma and PTSD, which would be less susceptible to individual responses to trauma and be limited to only those individuals who had directly experienced a potentially traumatic event (McNally, 2004; Norris, 1992).

For the purposes of this dissertation, the predominant definition as used in the current DSM-5 will be used. As suggested by McNally (2004) and the APA Anxiety,

OCD-Spectrum, Posttraumatic, Dissociative Disorders Work Group (APA, 2012), only individuals who have directly witnessed or experienced a serious threat to physical integrity (or death) will be included. As set forth in the still widely used Structured Clinical Interview for DSM-IV Axis I Disorders (SCID; First, Spitzer, Gibbon & William, 2002), examples of these threats to physical integrity could include: serious accidents or fire, rape or physical assault, life threatening combat experiences, seeing another person being killed or badly hurt, and life threatening major natural disasters. Learning of an event indirectly (e.g., on television, talking to a friend) or experiencing an event that did not include a threat to physical integrity (e.g., a relationship breakup; finding out about the death of a family member) will *not* qualify as a traumatic experience for the purposes of this dissertation. We propose to also include multiple different types of such traumatic events that may occur over one's lifetime, may be cumulative in nature (e.g., domestic violence, prolonged childhood sexual and physical abuse), and may be indicative of complex trauma reactions. Additionally, the definition used for the purposes of this research will include forms of trauma related to cultural or race-based factors that have caused a threat to the individual's physical integrity (e.g., hate crimes involving actual or threatened physical assault). Lastly, the person *need not* have a reaction that includes fear, helplessness or horror as a result of the trauma.

Disclosing and Discussing Trauma

This section outlines and discusses the process of disclosing traumatic experiences, or when individuals choose to share information about traumatic experiences with one another, and the subsequent ongoing discussion of trauma. First, the definition of trauma disclosure and trauma discussion is presented, followed by the

factors that go into the decision to self-disclose, including sociocultural reasons. This section concludes with a discussion of the factors that go into therapist facilitation of and responses to trauma disclosures and discussion, the impact of positive and validating responses and negative and invalidating responses on the trauma survivor in therapy.

Definition of trauma disclosure and discussion. The process of sharing information regarding traumatic experiences with another individual can be referred to as trauma disclosure. The term disclosure is relational and interpersonal in nature (Sorsoli, 2010). In trauma treatment, disclosure generally refers to the first time that an individual has shared this information with another, also referred to as a first-telling (Chaudoir & Fisher, 2010; Lutgendorf & Antoni, 1999). A first-telling includes both when an individual shares the information for the first time ever with another person, and also when she shares the information with a new individual for the first time. Therefore, a first-telling could potentially occur many times over the course of the trauma survivor's lifetime. Research has shown that children are more likely to disclose for the first time to their parents, whereas adults are more likely to disclose to friends and/or therapists (Arata, 1998; Lamb & Edgar-Smith, 1994; Roesler & Wind, 1994). In fact, Briere and Scott (2006) recommend that therapists assess each new client for a trauma history as part of a standard psychiatric evaluation. For the purpose of this study, trauma disclosure will refer to any time the client shares his or her experience of trauma with his or her therapist.

Linehan (1993) points out that although some individuals do disclose their trauma once or even multiple times, it is more unlikely that they continuously discuss their trauma history with the same person over a period of time. This ongoing dialogue of a

traumatic event or consecutive traumatic events is known as a trauma discussion, which may take place over the course of one therapy session or may be the focus of clinical concern for many years, and may vary according in accordance with the type of trauma experienced. Discussions of trauma also consist of the following: (a) descriptions of a traumatic event; (b) evaluative content about the traumatic event (e.g., beliefs, thoughts, attitudes); and (c) affective content (e.g., feelings and/or emotions regarding the traumatic event; Chelune, 1979; Cozby, 1973; Jourard, 1971; Omarzu, 2000; Pennebaker, Zech, & Rimé, 2001). Research has demonstrated that despite individual feelings of sadness and negative mood after the initial first-telling of a trauma to an experimenter involved in the study, discloser mood recovery tends to occur after a third discussion of the traumatic event, demonstrating the importance of a continued, ongoing trauma discussion (Lutgendorf & Antoni, 1999). For the purpose of this study, the term trauma discussion will refer to the ongoing and continued discussion of trauma-related information, including trauma-related content, trauma descriptions, subjective evaluations of the events, and affective responses to the event.

   The process of trauma disclosure and discussion. Of those individuals that do disclose or discuss trauma at some time in their lives, certain patterns have been illuminated in the research, mostly conducted with child sexual abuse disclosures: delayed disclosure, tentative disclosure, recantation following the initial disclosure, and reaffirmation of the abuse (Smith et al., 2000; Ullman, 2002). In addition, it is not a predictable or linear process, and there are many factors and considerations that affect an individual's decision to disclose and discuss trauma. This section begins by discussing the DPM model, and then factors related to the antecedent part of that model - factors that

have been shown to affect individuals' decision to self-disclose trauma, which include: type of trauma, ethnicity and sociocultural variables, gender, age, and feelings of shame and blame.

Chaudoir and Fisher (2010) contend that methodological issues make research concerning the full process of self-disclosure difficult to compare across individual studies. For example, some studies focus on the antecedent factors of disclosure, which include goals, the availability of an appropriate target, subjective appraisal of risk, value of the desired outcome, anticipated negative responses, and the type of relationship apparent between the discloser and disclosee without examining outcome effects of trauma disclosure (Derlega, Winstead, Greene, Serovich, & Elwood, 2004; Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003; Omarzu, 2000; Schneider, 1986; Troster, 1998). Some of these antecedent factors will be discussed next. Alternately, other studies focus solely on the outcomes of trauma disclosure without taking the antecedents into account. Chaudoir and Fisher (2010), therefore, argue that the majority of the research on trauma disclosure does not fully describe how the process unfolds.

To more fully delineate the process and in an attempt to reconcile the aforementioned limitations in trauma research, Chaudoir and Fisher (2010) proposed a Disclosures Processes Model (DPM) for stigmatized individuals; the five main components of this process include: antecedent goals (e.g., approach- versus avoidance-focused), the disclosure event itself (e.g., content and reaction of confidant), mediating processes (e.g., social support), long-term outcomes (e.g., individual, dyadic, and social/contextual), and a feedback loop (Chaudoir & Fisher, 2010). The feedback loop, as a response to the former components, therefore affects how an individual will deal

with future disclosure of traumatic event(s), based on her experience. Additionally, they

categorize trauma disclosure as a three-part process involving the decision to disclose

trauma by exerting self-control, effectively communicating information about the trauma,

as well as being able to cope with the outcome or consequences of the disclosure

(Chaudoir & Fisher, 2010).

The extant research on possible negative responses to trauma reveals several

categories, which include: unsupportive responses, invalidating responses,

inactive/indirect responses, unempathic responses and inappropriate emotional/behavioral

responses (Butler, 1978; Courtois & Watts, 1982; Josephson & Fong-Beyette, 1987; Lee,

Zingle, Patterson, Ivey, & Haase, 1976; Linehan, 1993; Linehan, 1997; Pruitt & Zoellner,

2008). Research on reactions to victims' disclosures of stigmatized experiences (e.g.,

health problems, crime victimization) has shown a variety of negative responses,

including: accusing the victim of lying, punishing or beating the victim, blaming the

victim, disbelief, ignoring the disclosure, being discouraged from discussing the trauma,

being treated differently following the disclosure, anger, neglect, and controlling and

egocentric responses (Ebert Johnson, Foley, & Fitzgerald, 2000; Herbert & Dunkel-

Shetter, 1992; Hong, Ilardi, & McCluskey-Fawcett, 2000; Testa, Miller, Downs, &

Panek, 1992). Because of the high levels of shame and embarrassment that accompany

particularly stigmatizing traumas, the process may even be more complex for those

individuals.

Regarding specific factors that are found in the antecedent part of the DPM,

individuals' sociocultural circumstances play a role in whether or not they choose to

disclose their trauma histories with others. At least five factors have been identified in

the literature that appears to affect one's decision to self-disclose traumatic experiences, which include: type of trauma, ethnicity/acculturation, gender, age, and feelings of shame and blame.

A key sociocultural variable that appears to be related to trauma disclosure is type of trauma experienced. Delayed disclosure or non-disclosure is particularly salient with individuals who have experienced stigmatizing traumas, including childhood sexual and physical abuse and rape (Foynes, Freyd, & DePrince, 2009). In fact, studies repeatedly show that survivors of childhood sexual abuse are the least likely to disclose their traumas to others, possibly facing sociocultural expectations for silence (Alaggia, 2005; Bedard-Gilligan, Jaeger, Echiverri-Cohen, & Zoellner, 2012; Roberts, Watlington, Nett, & Batten, 2010; Sorsoli, 2010; Ullman, 2010). In one review of literature, it was found that the primary reasons for non-disclosure in a sample of adults who had been sexually abused as children were fear of a negative reaction to the trauma disclosure, embarrassment/shame, fear of negative consequences, threats from the abuser, wanting to protect others, and fear of being blamed (Ullman, 2002).

As described earlier, there are levels of social acceptability associated with certain types of abuse, which ultimately create barriers to self-disclosure of trauma. For example, disclosure of a traumatic event such as a car accident or a natural disaster may elicit feelings of support and community, and bonding amongst others who have also experienced similar, common traumas, whereas childhood sexual abuse and intimate partner violence have a negative stigma associated with them (Sullivan, Schroeder, Dudley, & Dixon, 2010). In fact, some studies have shown that disclosure of these traumas can actually increase the frequency with which childhood sexual abuse survivors

are socially rejected, discriminated against, and invalidated (Ullman, 1995; Ullman 2002). Decreased social disclosure of trauma has been shown to be significantly correlated with greater interpersonal sensitivity, feelings of inferiority, and self-deprecation (Southwick & Charney, 2004).

In the U.S., ethnic minority women in general have experienced rates of interpersonal violence and trauma that far exceed that of the general population (Hien & Bukszpan, 1999), but are less likely to disclose trauma than white women (Ullman 1995; Ullman, 2010). Cultural norms may, therefore, not only impact the amount of disclosure but also the utility and benefit of it, as ethnic minorities are more likely to receive negative reactions to trauma disclosure, such as being blamed or not believed (Filipas & Ullman, 2001; Root, 1996). Additionally, levels of acculturation may also impact rates of trauma disclosure, as those who are more connected to the dominant culture disclose more to others who are from a similar culture (Garcia, Hurwitz, & Kraus, 2005). In these instances, non-disclosure of the trauma(s) may be therefore more protective than disclosing it and receiving a negative reaction in response (Glover et al., 2010).

Overall, research demonstrates that males tend to disclose less than females (Bedard-Gilligan et al., 2011). A study by McCormick (2008) found that in general, females were more willing to share emotions and experiences than men in general, but that females who had experienced trauma were less likely to disclose than women who did not have a trauma history. For both women and men, the choice to disclose or not may be impacted by worries of rejection, the perceived effect of the disclosure on others, and fears that relationships will be impacted negatively (Sorsoli, 2004). In particular, men who have experienced political violence are more likely to be affected by the stigma

of sexual trauma and are less likely to seek help than women (Vega & Alegria, 2001); in fact, political violence may become a normative experience for communities and may not be perceived as an issue that warrants mental health attention (Bleich, Gelkopf, & Solomon, 2003).

Age has also been identified as a key variable that determines whether a trauma disclosure will occur. In populations of children who have been abused, research has shown that characteristics of the child (e.g., age) along with characteristics of the trauma (e.g., duration, severity and relationship to the perpetrator) and family variables (e.g., maternal support) had effects on the presence and type of disclosure that children made (Kogan, 2004). A study which examined delays in disclosure of child rape in the National Women's Study found that younger age of onset of childhood rape, more severe rape, and longer duration of abuse were all associated with delaying disclosure in females (Smith et al., 2000). Age was a key factor in one study examining factors that predict the timing and recipient made by females who reported an unwanted sexual experience (USE) in childhood; children under the age of 7 at the time of USE were unlikely to tell immediately, highlighting a vulnerable population (Kogan, 2004). Conversely, other analyses revealed that young women whose USE occur between ages 7-13 are most likely to tell an adult and older adolescents (14-17) were more likely to disclose the USE to a peer than younger girls aged 7-10 (Kogan, 1993).

In regards to adult women, Starzynski, Ullman, Townsend, Long, and Long (2007) found that older women (i.e., women that were older than 30 at the time the study was conducted) were more likely to disclose sexual trauma to mental health professionals. They posit two explanations for these results. First, that greater financial

stability (e.g., health insurance and more stable employment) may explain, in part, the positive relationship between age and utilization of mental health services, which then leads to the subsequent disclosure. Second, they posit that these results may be explained by the increased passage of time since the trauma among older women, which therefore could lead to increased psychological problems and increased help-seeking behavior (Starzynski et al., 2007).

The experience of shame also plays a significant role in a survivor's decision to disclose trauma. Reports of a USE by a stranger are more likely to be believed by family members and may be less likely to result in embarrassment and shame attributed to the trauma survivor (Ullman, 1999). A recent study by Platt and Freyd (2012) examined the role that shame plays following the experience of a traumatic event (e.g., a betrayal by a close other) or events in a sample of undergraduate students, which contributes significantly to the emotional stress that an individual experiences. This study found that individuals who scored high on questionnaires measuring negative automatic assumptions (NUAs) were more likely to have experienced a traumatic event than to report never having experienced a trauma, and that high NUAs predict a shame response in participants after receiving negative feedback on an academic task (Platt & Freyd, 2012). Similarly, Farber and Hall (2002) found that shame and embarrassment played a significant role in clients' difficulties discussing sexual issues (i.e., abuse, sexual fantasies and experiences), which resulted in decreased disclosure rates despite being informed of the confidentiality of the therapeutic relationship. Other studies which have examined shame and guilt in the aftermath of traumatic events demonstrates that these variables are associated with compounded affective processes that are evident in and can

be linked to PTSD, depression, substance use disorders, and dissociation (Dorahy &

Clearwater, 2012; Whiffen & MacIntosh, 2005; Wilson, Drozdek, & Turkovic, 2006).

Research also demonstrates that individuals who have been exposed to political violence

may experience shame or hesitancy in discussing event details with health professionals,

particularly if sexual trauma was experienced as well (Barthauer & Leventhal 1999;

Kogan, 2004).

Additionally, blame has been shown to be an important characteristic that affects

whether a trauma survivor chooses to disclose. Analyses of a sample of female

childhood sexual abuse (CSA) survivors found that self-blame and family blame were

related to higher PTSD scores post-trauma, and that the strength of the relationship

between PTSD and blame was greater in cases of more severe, isolated and extrafamilial

abuse (Cantón-Cortés, Canton, & Cortés, 2011). These findings demonstrate that

addressing feelings of shame, guilt, and blame following the experience of CSA and

other traumas may be particularly advantageous with clients.

Therapist facilitation of and responses to trauma disclosure/discussion.

Studies that have examined clinician responses to trauma disclosures have generally

found that clients endorse a mixed range of reactions from their therapists, some being

positive, some neutral and some negative (Josephson & Fong-Beyette, 1987; Palmer,

Brown, Rae-Grant, & Loughlin, 2001). While there are vast forums and individuals to

whom a trauma survivor may choose to disclose (e.g., parent, friend, coach, teacher,

doctor), disclosure can and does often occur when a trauma survivor seeks mental health

services either as directly related to the trauma, as a result of their symptoms, or for

unrelated reasons. As providers of mental health services, therapists therefore can and

often should elicit trauma disclosures from their clients in a sensitive and appropriate manner. Thus, the following subsections focus on health and mental health professionals as the facilitators and responders to trauma disclosures and discussion.

Eliciting Trauma Disclosure and Discussion in Psychotherapy

Because the disclosure and discussion of trauma is often a difficult process, with the possible client perception that discussion of the traumatic event will result in re-experiencing and/or negative consequences, therapists may need to, at times, elicit these topics in therapy. Sorsoli (2010) states that there are also a number of techniques that therapists can utilize in order to facilitate disclosure. During the intake phase, therapists may choose to take an active stance in assessing for trauma histories, both through the use of questionnaires and by directly asking the client about specific traumas. They may also request intake paperwork that includes screening questions regarding the experience of trauma, and follow-up if these are endorsed in-session. Should trauma be endorsed in the aforementioned verbal and non-verbal scenarios, a therapist may then choose to ask more specific trauma-related questions as related to details of the event(s) as well as assess more thoroughly for related symptomatology. The use of a trauma-specific assessment measure (e.g., Trauma Symptom Inventory – Second Edition (TSI-2); Briere et al., 1995) may also help to clarify symptomatology and further investigate which domains are most negatively affected as a result of trauma.

In other words, therapists can elicit trauma disclosures in verbal and written forms. Verbal discussion occurs when any oral communication is made from the client to the clinician about the trauma occurrence, including their first-telling of the trauma to subsequent sessions where it is discussed in detail. Additionally, written disclosures

involve communication about the occurrence of trauma through any written materials, including intake paperwork or endorsement of trauma-related questionnaire items. Given advancements in technology, these trauma discussions can also take place over video chat or during phone sessions with clients, or through email correspondence.

Research has demonstrated that both written and verbal discussions of trauma may lead to positive and reparative outcomes for clients who engage in then with their therapist (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011). In particular, verbal expression of trauma disclosure allows for reciprocal responses from the listener and thought restructuring opportunities, while written trauma disclosure is a more individual process that may be useful with individuals who have an inhibition to disclose or may fear invalidation (Baddeley & Pennebaker, 2011; Chaudoir & Fisher, 2010; Segal, Tucker, & Coolidge, 2009). Written disclosure of trauma may be particularly useful with clients who have experienced stigmatizing trauma (e.g., childhood sexual abuse), who may fear negative reactions from others (Chaudoir & Fisher, 2010)

In part, encouraging a client to disclose trauma through these means challenges them to structure their experience cognitively, inviting them to reorganize and restructure this content to make it coherent for others (Pennebaker & Francis, 1996). Additionally, the cognitively structured verbal or written experience uses meaning-making and cognitive processes that encourage the client to develop a clear and linear representation of the trauma, and present it in relation to their entire life story (Freer, Whitt-Woosley, & Sprang, 2010).

Research supports the idea that written trauma disclosures are efficacious in trauma treatment. A study by Deblinger et al. (2011) found that children treated from a

Trauma-Focused CBT framework who completed a written narrative of the trauma events displayed greater symptom relief than children who did not have a written trauma component in the course of their treatment. Use of positive written narratives (as opposed to negative written, positive spoken, and negative spoken narratives) have been found to be the most comfortable of a task with undergraduate students who expressed unresolved upsetting experiences, while also resulting in greater adaptive cognitive changes as compared with the other groups (Segal et al., 2009). For the purposes of this study and nature of the available data, a focus on verbal discussions of trauma will be maintained.

Researchers have identified key variables that appeared to contribute to facilitation of client disclosure via written or verbal means, which included the therapists' skill in building the therapeutic relationship, the strength of the therapeutic relationship at the time of disclosure, therapists' acceptance of the client, and clients' perceptions of not being judged (Farber, Berano, & Capobianco, 2004; Kelly & McKillop, 1996; Stiles et al., 1990). Overall, facilitating client disclosure appears to be effective when done in a sensitive and non-threatening way (Balmforth & Elliott, 2012). In a qualitative study that examined one individual's trauma disclosure, the client could not immediately engage with her therapist's empathy for her disclosure of childhood sexual abuse, but was able to come back to it later in her process with continued support (Balmforth & Elliott, 2012). A therapist should therefore move at the client's pace, and be aware that all clients are at different points in their process, with some being more readily able to discuss trauma than others. Most importantly, even though she was not yet ready to process her repeated traumas, she reported feeling affirmed and positive following her disclosure which had

been met with support and non-judgment (Balmforth & Elliott, 2012). Similarly,

Linehan's (1993) research demonstrates that trauma survivors whose disclosures are met

with positive and validating reactions are more likely to discuss the trauma again in the

future. These therapist responses to trauma disclosures are discussed next.

Therapist responses to discussion of trauma in psychotherapy. When a client

decides to disclose or discuss personal information about himself or herself to his or her

therapist, a wide range of therapist reactions can occur. When dealing with trauma

survivors, the way in which a psychotherapist reacts to a client's traumatic disclosure has

the potential to create positive and healing effects, negative and re-traumatizing effects,

or to not affect them at all. This subsection briefly describes the different ways that

clinicians can respond to a client's trauma disclosure, which can lead to experiences of

validation or invalidation.

In general, there is a lack of research that examines and systematically measures

the positive ways that therapists respond to trauma disclosures (Beutler & Hill, 1992).

According to what *is* known, however, the different types of positive responses can be

placed into the following categories: supportive responses, validating responses,

active/straightforward responses, empathic responses and positive emotional/behavioral

responses (Beutler & Hill, 1992; Josephson & Fong-Beyette, 1987; Kessler & Goff,

2006; Linehan, 1993; Linehan, 1997; Palmer et al., 2001). One study found that mental

health providers who were perceived as caring and that communicated on the same level

of the veterans facilitated trauma discussions (Jeffreys, Leibowitz, Finley, & Arar, 2010).

There is less known, however, about the individual characteristics or attributes of

veterans that contribute to the facilitation of trauma disclosure other than that of their

perceptions in relation to the healthcare provider. Some preliminary evidence gathered

quantitatively from one previous study suggest that in a veteran sample, approximately

60% of individuals seek help at the urging of others and approximately 40% sought help

due to a concern that they had PTSD (Leibowitz, Jeffreys, Copeland, & Noel, 2008).

Conversely, therapists can also respond to trauma disclosures in a negative or

neutral way, or have no reaction at all (Gable, Gonzaga, & Strachman, 2006). In a study

that examined trauma disclosures to health care professionals by veterans returning from

war, some of the barriers to trauma disclosure included: lack of trust in the provider, fears

about the potential negative consequences of the disclosure, and trauma avoidance

(Jeffreys et al., 2010). Surprisingly, little to no research has examined the ways in which

disclosure delays and sociocultural pressures for non-disclosure impact trauma narratives

(Sorsoli, 2010).

Therapist Self-Disclosure

Historically, the use of therapist self-disclosure has been debated across

theoretical orientations. Yalom (1985) noted that therapist self-disclosure "more than any

other single characteristic, differentiates the various schools of therapy" (p. 212). For

example, the traditional psychoanalytic view of the therapist as a mirror indicates a

restrictive use of self-disclosure, whereas humanistic and feminist schools of thought

embrace therapist self-disclosure as a useful and necessary part of the therapeutic

encounter.

Due in part to theoretical differences, research on therapist self-disclosure lacks

clear and consistent operational definitions and methodology (Capobianco & Farber,

2005; Henretty & Levitt, 2010; Hill & Knox, 2001; Knox, Hess, Petersen, & Hill, 1997).

Unclear definitions of self-disclosure are cited as a major limitation in nearly all of the current literature on this topic. As a result, the use of therapist self-disclosure and its effect on the therapeutic relationship has yielded mixed results.

Another area of confusion in the research on self disclosure concerns how often it occurs. Research on therapist self-disclosure from the last forty years, which was compiled more recently, cited frequency rates of therapist self-disclosure anywhere from 1-13% in psychotherapy sessions (Hill & Knox, 2001). These results varied greatly across studies and employed mixed methodology, thus making them difficult to compare. However, some researchers contend that because certain forms of self-disclosure are considered a common part of the therapeutic dialogue, and therefore are omitted from self-disclosure reports, self-disclosure may actually occur at higher rates than is presumed (Farber, 2006; Ziv-Beiman, 2013).

Although most authors acknowledge that a therapist's decision to intentionally or even unintentionally self-disclose holds ethical considerations, attention has been re-focused over the years to a discussion of the clinical issues surrounding self-disclosure; that is, whether it is a therapeutically useful intervention rather than if it is an ethical one (Peterson, 2002). However, ethical issues remain relevant and should be discussed.

This section first discusses the historical underpinnings of therapist self-disclosure in light of different theoretical orientations, and traces the development of its definition to what predominantly is believed today. Next, a discussion of the definitions, types and categories of self-disclosures is presented, as well as the self-disclosure debate as related to countertransferential reactions and ethical considerations and guidelines. Then, self-disclosure in looked at in the context of the therapeutic relationship; more specifically, a

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discussion of student therapists' use of self-disclosure and the positive, negative, and mixed effects are presented, including a critique of the current body of research. Lastly, self-disclosure as specific to trauma treatment is discussed, including possible reasons and guidelines for the use of self-disclosure, and research findings as related to self-disclosure and trauma treatment.

History of the View of Self-disclosure Across Theoretical Orientations

This subsection discusses the historical development of self-disclosure, starting with psychoanalysis. It then moves to more recent, emerging schools of thought, including humanistic, cognitive-behavioral, and multicultural approaches to treatment.

Psychoanalysis. Reflecting the traditional psychoanalytic school of thought, Freud (1912) referred to therapist self-disclosure by stating, "The physicians should be impenetrable to the patient, and like a mirror, reflect nothing but what is shown to him" (p.18). It was Freud's belief that the goal of the therapist was to act as a "blank screen," upon which the patient could project his or her transference in order for the therapist to then make an accurate interpretation (Henretty & Levitt, 2010). Therapist self-disclosure represented the direct opposite of Freud's belief of therapist anonymity and personal restraint (Curtis, 1981). To Freud, therapist self-disclosure "came to be viewed as the antithesis of the detached observer" (Simon, 1988, p. 404). He believed that self-disclosure would distort the patient's transference, making it inaccurate and disallowing its resolution, which is one of the core mechanisms of change in psychoanalytic psychotherapy.

Additionally, traditional psychoanalytic theory posits that self-disclosure is actually a result of the therapist's countertransference, suggesting that the intention of the

disclosure is to serve the therapist's needs rather than the client's (Peterson, 2002). Thus, self-disclosure can be viewed as a symptom of the therapist's countertransference (Lane & Hull, 1990). Goldstein (1994) describes how therapist self-disclosure of personal thoughts, feelings, or experiences has been traditionally assumed to contaminate the therapeutic process, and can be exploitative if used without discretion. In fact, traditional psychoanalytic writers have been most strongly opposed to therapist self-disclosure because it could distort the patient's transference, resulting in non-resolution of that transference in therapy (Edwards & Murdock, 1994). As Gutheil and Gabbard (1995) suggest, therapists who self disclose "must be sure that their reasons for doing so are not related to their own unfulfilled needs in their private lives" (p. 222), as this could result in exploitation of the client. Freud also believed that therapists' disclosures would highlight their weaknesses and vulnerabilities, resulting in decreased patient trust in their abilities, and therefore negatively affecting the therapeutic alliance (Curtis, 1981).

Despite Freud's firm stance on non-disclosure as he described, it has also been pointed out that he, at times, shared his personal dreams and early childhood memories with his patients (Barglow, 2005; Bottrill et al., 2010), suggesting that he did not adhere to this idea as strictly as he had stated. Furthermore, Freud's definition does not take into account self-disclosure that is unintentional in nature, such as the therapists' gender, style of dress, or office décor, all of which reveals something personal about that individual. For this reason, Mahalik, Van Ormer, and Simi (2000) contend that his mirror analogy is virtually impossible, given that self-disclosure occurs whether the therapist offers information intentionally or otherwise. Recognizing the importance of the therapeutic relationship, one traditional Freudian theorist stated that there was a difference between

"a mirror and an inanimate thing" (Simon, 1988, p. 404). Similarly, in 1951, Annie

Reich was quoted as stating in regards to psychoanalysis that, "to be neutral does not

imply that the analyst has no relationship at all to the patient" (as cited in Simon, 1988, p.

405), suggesting that the therapeutic relationship remains an important construct even in

the more conservative view of the therapist-patient dyad. Renik (1995) and Greenberg

(1990) also argued against the "pretense of anonymity" (p. 476), and theorized that

therapist self-disclosure was not only an important but also an inevitable part of the

course of therapy (Renik, 1995).

As a result, more contemporary psychoanalysts have acknowledged that complete

anonymity is not possible (Audet, 2011; Bottrill et al., 2010). For example, Bernstein

(1999) contends that the goal of neutrality "has been gradually dismantled as a virtually

impossible stance to uphold" (p. 595). Simon (1988) writes that although the definition

of neutrality varies greatly according to individuals adhering to different theoretical

models, there has been a shift from the traditional psychoanalytic view of neutrality to

increased activity on the therapist's part, including intentional self-disclosure.

Thus, in recent years, there has been a marked change in thinking about self-

disclosure, even by traditional psychoanalytic therapists (Knox & Hill, 2003). One study

was identified within the research on therapist self-disclosure that concluded that

therapists practicing from a psychodynamic approach actually used self-disclosure ("I"

and "me" statements) more with clients than therapists who were practicing from a

cognitive-behavioral approach (Stiles, Shapiro, & Firth-Cozens, 1988); the only study

located in the review of the literature that measured such variables. Bernstein (1999)

similarly contends that analysts are no longer discouraged from revealing their own

personal thoughts, feelings, and insights, but rather encouraged to discuss how these constructs may be useful to their patients, with the goal of facilitating client self-exploration (Bottrill et al., 2010). Rather than remain a "blank screen," the analyst becomes a human being, capable of a wide range of emotions. In other words, some current psychoanalysts believe that self-disclosure can work in conjunction with transference rather than against it (Audet, 2011; Bottrill et al., 2010).

Humanistic, person-centered and existential therapies. In 1951, in an attempt to steer the field of psychotherapy away from the traditional medical model and the physician-patient relationship in psychoanalysis, Carl Rogers suggested the term "counseling" might be a more appropriate way of characterizing the dyadic relationship (Curtis, 1981). In 1958, Humanistic psychologist Sydney Jourard was acknowledged with first using the term "self-disclosure" in his seminal work on the topic, giving a name to the controversial concept that had been debated since the field of psychology emerged.

Rogers is credited as pioneering the movement of humanistic psychology, which is based on the assertion that therapist self-disclosure can be used as a tool to facilitate and bolster the therapeutic relationship (Edwards & Murdick, 1994; Peterson, 2002), which stands in sharp contrast to the psychoanalytic school of thought. Rogers, in agreement with Jourard, believed that therapist self-disclosure served to establish rapport with clients, and foster the relationship through positive regard, empathy, and genuineness (Audet & Everall, 2010; Barrett & Berman, 2001). They believed that the use of therapist self-disclosure, in turn, would instill trust in the patient, leading to increased honesty and openness in therapy sessions, which humanists refer to as congruence (Peterson, 2002). Furthermore, humanists believed that therapist self-

disclosure reveals the fallibility and humanness of the therapist, serving to demonstrate to the client that the relationship is one of equality (Audet, 2011). Rogers proposed that positive change could occur by means of this genuine and honest relationship.

In 1981, Curtis cited several early studies on self-disclosure within the dyadic context, which found that a self-disclosure offered by one party actually increased a reciprocal self-disclosure by the second party (Davis & Skinner, 1974; Gary & Hammond, 1970; Jourard & Resnick, 1970). This finding lent empirical support to Rogers' theory that therapist self-disclosure is positively correlated with client self-disclosure, creating congruence. Disclosure reciprocity is one of the most studied interpersonal effects of self-disclosure, which supports three findings: that therapist self-disclosure increases trust and liking from the client's perspective, that social norms as related to equity informs client self-disclosure, and that of self-disclosure as a result of therapist modeling (Derlega & Berg, 1987).

A more recent study by Hill and Knox (2001) found that humanistic therapists were more likely to self-disclose than psychoanalysts, both by self-report ratings and when observed by experienced clinical psychologists. This finding is consistent with what the previous literature on therapist self-disclosure suggested in light of theoretical orientations, suggesting that theory does inform practice.

Since Rogerians advocated for the use of therapist self-disclosure in their practices, therapists from various other similar schools of thought adopted it as a useful tool as well. Person- or client- centered and existential approaches are next discussed. The client-centered modality, which was born out of Rogerian humanistic theory, has contended that therapists' self-disclosure in the form of modeling openness, strength, and

vulnerability in sessions invites clients to follow their lead, which creates trust, empathic understanding, and a perceived similarity between client and therapist (Henretty & Levitt, 2009).

Rather than focus on the philosophical debate surrounding therapist self-disclosure, the client-centered approach appears more concerned with the pragmatics and technique of the disclosure, advocating a mirror approach in therapy (Mathews, 1988). Unlike Freud's blank screen analogy, Rogers, who practiced the client-centered approach, contended that this mirror displays both warmth and impartiality, reflecting back to the client his or her thoughts and feelings in a supportive and non-judgmental way. Through this process, Rogers believed that mirroring would allow for the client's potential for growth to emerge, allowing the therapist to recognize and use mirroring in helping the client to grow and change (Knox & Hill, 2003; Mathews, 1988). Rogers further postulated that therapist self-disclosure could be used as a means of demystifying the therapy process (Knox et al., 1997). As the name of the theory suggests, therapist self-disclosure essentially serves to enable to client to see his or her therapist as human, allowing therapists to serve as role models, normalize the client's struggles, and balance the power in the therapeutic relationship (Knox & Hill, 2003).

Irvin Yalom, an existential therapist, agreed with Rogers' belief of genuineness and honesty. In his own work, Yalom (1999) suggested that therapists should be as real within the therapy hour, as outside of it. This belief is consistent with the principles of authenticity, transparency, and egalitarianism that Yalom and other existentialists practice, which are informed from theory which stresses concern for the intersubjective aspects of the therapeutic relationship (Geller, 2003).

Rational-Emotive/cognitive-behavioral therapy. Rational Emotive Behavior Therapy (REBT), which is considered by many to be the earliest form of Cognitive-Behavioral Therapy (CBT), posits that therapist self-disclosure plays an important role in modeling for the client. REBT itself involves a framework aimed at identifying activating events, irrational beliefs, and behavioral consequences that requires both the client and therapist to use different examples of situations, thoughts, feelings and actions to identify these aspects and dispute irrational beliefs (Peterson, 2002). Given the nature of REBT, Dryden (1990) suggested that therapist self-disclosure of these different examples could model to the client how internal and external processes can lead to psychological distress. For example, Dryden discloses her own personal struggles with anxiety and stuttering to clients, which she feels demonstrates to her clients a real-life example of the maintenance of her anxiety and shows her fallibility and humanness to them (Peterson, 2002). Additionally, Carew (2009) notes how self-disclosure can serve to normalize clients' symptoms and suffering as well as instill hope that through therapy, they would be able to reduce them. Peterson (2002) asserts that therapist self-disclosure is vital when working within a REBT framework, so much so that it would be considered unethical under the code of beneficence not to do so.

Many proponents and practitioners using other CBT approaches in treatment also view self-disclosure as an important therapeutic tool. Similar to the humanistic school of thought, many therapists who practice CBT see therapist self-disclosure as a means to foster client change and enhance the therapeutic relationship (Knox & Hill, 2003). On the most basic level, therapist self-disclosure in CBT models an effective and appropriate way for clients to disclose information and share experiences, which is the basis on which

behaviorally-based approaches like CBT are built. Through the therapist's process of

using self-disclosure to challenge clients' core beliefs, presumptions about the world, and

automatic thoughts, clients are shown evidence and provided with feedback about how

they present interpersonally to others (Goldfried, Burckell, & Eubanks-Carter, 2003).

Additionally, therapist self-disclosure helps to normalize the client's struggles as well as

model and reinforce positive adaptive coping skills that the client is able to use outside of

sessions (Audet & Everall, 2010; Hill & Knox, 2003). Many proponents of CBT have

advocated for therapist disclosure of personal examples of coping mechanisms that have

been successful in their lives (Dryden, 1990; Goldfried et al., 2003). Stiles et al. (1988)

determined in their study that CBT therapists who were providing psychotherapy to

clients utilized self-disclosure ("I" and "me" statements) often, making up approximately

12% of therapist verbalizations across sessions, behind acknowledgments and

edifications. When discussing self-disclosure, Leahy (2008) writes, "It is important to

recognize what most cognitive-behavioral therapists are doing…is not cognitive-

behavioral therapy; rather it is relating to another person" (p. 259). This quotation

demonstrates the important nature of the development of the therapeutic relationship in

CBT, which can occur through the use of therapist self-disclosure.

       Feminist, systemic and multicultural therapies. Individuals who adhere to

feminist theory strongly advocate for the use of therapist self-disclosure, as it is built

upon the idea that the therapist-client relationship should be one of equality (Simi &

Mahalik, 1997). To achieve that goal at the start of therapy, feminist therapists use

disclosure of professional credentials or sexual orientation to help clients make informed

decisions about the therapist with whom they wish to work (Simi & Mahalik, 1997).

Throughout therapy, feminist therapists would make every attempt to equalize the power relationship between themselves and the client as an ongoing condition for working together, including sharing personal and professional information about themselves. This approach lies in contrast to the "expert-to-patient" relationship that exists in traditional medical models, which can make individuals feel objectified (Audet & Everall, 2010). In a more balanced relationship, the therapist can then act as more of a role model for the client, at least initially, serving to guide them based on their own experiences (Brown & Walker, 1990).

Thus, self-disclosure in this approach serves to transmit feminist values, balance power, create solidarity in the relationship, promote client growth, reduce client shame, empower the client, explicitly acknowledge the power dynamics of the therapeutic relationship, and form connections between personal and political issues (Knox & Hill, 2003; Peterson, 2002). Similarly to REBT-oriented therapists, Peterson (2002) contends that feminist therapists who do not disclose to their clients could engage in ethical wrongdoing according to the same principle.

There has also been some discussion about the use of therapist self-disclosure among proponents and practitioners of family therapy (FT), which seeks to understand how psychological problems are developed and maintained in the social context of the family (Nichols & Schwartz, 1998). The early structural model of FT evolved from the traditional medical model and closely resembled the traditional psychodynamic approach in regards to therapist self-disclosure, asserting that it shifted the focus from the family to the therapist (Carew, 2009). Over the years, however, therapist self-disclosure came to be seen as helpful and useful particularly when working with families. For example, the

structural model of FT uses self-disclosure as a way of joining with parents and children in their experiences, and the symbolic experiential model views therapist self-disclosure as useful and essential when working with families.

Lastly, many therapists who adhere to a multicultural framework are also proponents of therapist self-disclosure, particularly with clients from socioeconomic backgrounds that are different from their own (Knox & Hill, 2003). Research has found that clients from diverse backgrounds who are culturally different from their therapists may be less likely to trust their therapists initially (Sue & Sue, 2012). For example, Thompson, Worthington, and Atkinson (1994) found that African American clients tend to disclose less to Caucasian therapists as compared to racially similar therapists. Some therapists feel that it may be necessary to self-disclose in order to establish rapport with multicultural clients. Gallardo, Johnson, Parham, & Carter, (2009) posit that therapist mistrust may be manifested in therapy when clients refuse to disclose information that they believe may be invalidated, particularly by therapists who use a traditional blank slate or mirror approach to therapy. He goes on to contend that the use of appropriate therapist self-disclosure that includes discussing personal and collective experiences can be used to establish rapport, build trust, and reinforce credibility with multicultural clients. Similarly, Helms and Cook (1999) contend that culturally dissimilar clients may develop a greater sense of trust in their therapist when that therapist is able to acknowledge cultural disparities and similarities through the use of self-disclosure. Although it has been postulated that therapist self-disclosure with multicultural clients is essential in establishing a trusting relationship, there appears to be an absence of research that examines its impact empirically.

Definition of Therapist Self-Disclosure

The definition of therapist self-disclosure is likely to vary based on professionals'
theoretical orientation, training experiences, and personal characteristics. As described in
the previous sections on theoretical orientation, the schools of thought that have
developed in the field of psychology over the years view therapist self-disclosure
differently. Clinicians in various training programs may also be given different
information about self-disclosure based on their institutions' training models and the
supervision they receive. Likewise, personal characteristics of clinicians may influence
whether or not they choose to utilize verbal self-disclosure in various contexts, among
their clients, and across their careers. Additionally, therapist self-disclosure can be non-
intentional in nature, at times occurring simply because of the physical appearance of the
therapist (e.g. gender or marital status). Lastly, therapist self-disclosure may occur as the
result of a therapist's countertransference towards the patient, which can occur both
intentionally and non-intentionally and can have both positive and negative effects.
This subsection focuses on the definitions, types and categories of therapist self-
disclosure.

Although a few earlier references to self-disclosure can be found in the literature,
Sydney Jourard is recognized as pioneering research regarding self-disclosure and
coining the term in 1971 as we now study it today (Derlega & Berg, 1987). Jourard
originally posited that self-disclosure in general was both a sign and a cause of a healthy
personality; more specifically, he defined it as a healthy personality characteristic that
was positively correlated with other healthy personality characteristics (such

characteristics were not specified in their publications; Derlega & Berg, 1987; Jourard, 1971).

Years after Jourard first coined the term, other theorists attempted to systematically define the term self-disclosure in order to be able to quantify it in research settings. Curtis (1981) spoke of and defined self-disclosure in relation to "I" or "we" statements made by therapists, which appears to be a rather broad generalization and does not take into account more subtle ways that self-disclosure occurs. In 1984, continuing the focus on verbal statements, Weiner and Shuman defined self-disclosure as statements that give more than professional expertise or when the therapist is purposely more open with the client.

In the last decade, researchers have continued to try to define self-disclosure. Mahalik et al. (2002) define therapist self-disclosure as "a process by which the therapist reveals aspects of himself or herself to the client," (p. 190) suggesting that this process could be verbal, non-verbal, intentional or non-intentional in nature. From this perspective, as was mentioned earlier, self-disclosure becomes virtually unavoidable and impossible to fully measure, given that many of our non-verbal physical and personal characteristics are visible to clients during the course of treatment. This aforementioned definition also limits how self-disclosure can be measured systematically, given that these unavoidable self-disclosures occur whether the therapist intends to reveal them or not. Although the benefit of Mahalik et al.'s definition is its breadth, a more concrete definition that involves observable self-disclosure is needed for the purposes of this study.

Other researchers have defined self-disclosure as "personal and private information that would not typically be shared with a stranger" (Barrett & Berman, 2001, p. 598). This definition, while slightly more specific than the previously described ones, requires a subjective stance because the level of information that one might share with a stranger would vary widely across individuals.

Hill and Knox (2002) provided the most widely accepted and used definition in current research. They contend that self-disclosure can generally be defined as verbal statements through which therapists *intentionally* (or verbally, for the purposes of this study) communicate information about themselves to their clients (Hill & Knox, 2002). This definition allows one to objectively measure self-disclosure based on verbal statements that are made by therapists. Verbal self-disclosures can be divided into further subtypes and categories, which are described next.

Types of therapist self-disclosure. There are three widely recognized forms of verbal self-disclosure, which are differentiated by both researchers and theorists from different schools of thought: self-disclosing statements, self-involving statements, and reciprocal self-disclosure. First, self-disclosing statements, which are also referred to as factual disclosures or self-revealing statements, occur when a therapist reveals personal information or facts about him or herself to his or her client (e.g., professional credentials; sexual orientation). These disclosures can include any aspect of the therapist's life outside of the therapeutic encounter, including revealing personal life circumstances, beliefs, experiences or values (Audet & Everall, 2010). Secondly, self-involving disclosures occur when the therapist reveals immediate or non-immediate

feelings or impressions about the client or the therapeutic relationship (Bottrill et al., 2010; Knox, Hess, Peterson, & Hill, 1997).

Self-involving statements have traditionally been viewed as a more acceptable form of disclosure as compared to self-disclosing statements (Audet & Everall, 2010), because they maintain focus on the client and stem from a relational approach, serving the function of pointing out to the client how others may perceive them (Myers & Hayes, 2006; Tantillo, 2004). It has been suggested that self-involving disclosures, as opposed to factual disclosures, are less likely to cause boundary transgressions because they involve information that directly involves the client (Audet & Everall, 2010). However, if they occur as a result of countertransference and the therapist's desire to serve his/her own needs above that of the client's, they might also become problematic in nature.

Self-disclosing and self-involving statements can further be divided into non-immediate and immediate (Audet & Everall, 2010), and positive and negative categories (Henretty & Levitt, 2010; Hill, Mahalik & Thompson, 1989). Non-immediate forms of disclosure refer to personal information regarding the therapist's life outside of therapy, whereas immediate forms of disclosure focus on the "here-and-now" (Audet & Everall, 2010, p. 328) including current personal reactions to the client in the therapy session (McCarthy & Betz, 1978).

In 1991, Robitschek and McCarthy defined non-immediate *positive* self-disclosing statements as "expressions by the counselor about his or her past which is consistent with the self-experience of the client" (p. 218) and non-immediate *negative* self-disclosing statements as "aspects of the therapist's past that were not consistent with the client's response" (e.g., I also went through a divorce so I can understand your anger

vs. It helps me feel less angry when I try to focus on the positive). The first example

demonstrates that the therapist had an experience consistent with the client's while the

latter example demonstrates that the therapist had an experience inconsistent with the

client's (e.g., focusing on the positive when the client was talking about a negative

emotion/anger). Robitschek and McCarthy also categorized immediate self-involving

statements as positive or negative (e.g., I am *proud* of you for seeking help vs. I am

worried that you are holding back in therapy), but differ because they do not explicitly

include information regarding elements of the therapist's past (other than CT) and focus

directly on the client. In this case, the first statement conveys an optimistic or

encouraging immediate experience or feeling taking place in the room and is directly

related to the client, while the latter is a constructive statement of concern, which

Robitschek and McCarthy (1991) classify as negative in nature. The following tables

provide examples of how the literature categorizes self-disclosing statements followed by

self-involving statements, both in immediate and non-immediate forms, and positive and

negative:

Table 1

Examples of Positive and Negative Self-Disclosing Statements

Self-disclosing statements	Positive [Consistent]	Negative [Inconsistent]
Immediate	T: "I saw that movie."	T: "No, I've never been there."
Non-immediate	T: "I went through something similar a while back and can relate."	T: "It makes me feel less angry when I try to focus on the positive." [when client expressing anger]

Table 2

Examples of Positive and Negative Self-Involving Statements

Self-involving statements	Positive [Encouraging]	Negative [Challenging]
Immediate	T: "I'm feeling very connected with you right now."	T:"As you continue to come late to sessions, I'm feeling increasingly frustrated."
Non-immediate	T: "This reminds me of our past session when we both felt something similar to what we're experiencing now."	T: "I've noticed that in the past we haven't been on the same page."

Research that distinguishes between non-immediate and immediate statements, has found that immediate self-involving statements that "maintain focus on the client in the here-and-now" are viewed by observers and clients as the more acceptable form of disclosures not only because of their relational focus, but also because they highlight and provide feedback regarding the client's interpersonal style (Audet & Everall, 2010; Hill, 2004; Hill et al., 1989). This assertion is consistent with past analogue research involving vignettes that found that clients perceived positive self-involving and reassuring disclosures as more helpful than negative self-involving and challenging disclosures (Andersen & Andersen, 1985; Remer & Buckholtz 1983; Watkins, 1990). Positive self-involving and reassuring disclosures led clients to feel more comfortable, were more pleasant, and helped clients experience themselves at deeper levels, indicating that they led to client growth in a more productive way than negative self-involving or challenging disclosures. They also fostered equality in the relationship, making therapy less of a vulnerable place and therefore safer to explore underlying issues (Hill et al., 1989). But since these particular analogue studies did not differentiate between immediate and non-

immediate disclosures in their methodology, no conclusions about the specific forms of self-disclosure and their usefulness can be made.

Because of the sheer majority of verbalizations that could be made by a therapist, it can be a difficult and subjective process to attribute self-disclosures to a purely positive or negative category. For example, a therapist might make a comment that appears to be positive on the surface level but may actually represent a boundary transgression that may be damaging to the client or therapeutic relationship (e.g., "You're my favorite client" or "I find you very attractive"). Furthermore, very little research focuses on the use of self-disclosure with trauma survivors. Given the levels of awareness and sensitivity that must be used when working with this population, it is increasingly important to begin to examine both the use and impact that therapist self-disclosure has on individuals who have experienced trauma. For the purposes of this study, positive and negative or "encouraging" and "challenging" categories were considered for use in coding, but it was determined that it would be beyond the scope of the study to infer the therapists' intent and tone and too subjective of a process to gather accurate data in this area. Therefore, the following codes were selected for use in the present study: SDIS-DEMO, SDIS-CON-DEMO, SDIS-INC-DEMO, SDIS-PERS, SDIS-CON-PERS, SDIS-INC-PERS, SINV-PERS, SINV-MIST, and NOS/Other (a complete description of these codes can be found in Appendix A). Content analysis of the codes that were developed for the purposes of this study are included in the results and discussion sections below.

Another type of self-disclosure is reciprocal self-disclosure. Barrett and Berman (2001) propose that reciprocal self-disclosure occurs when a therapist self-discloses in direct response to comparable client disclosures (e.g., (client): I'm feeling really down

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today; (therapist): I know how that feels). It is similar to immediate self-disclosure in that it focuses on the here-and-now, but differs because it is always done in response to something the client says. Such reciprocal self-disclosure has been thought to limit the possible disruption in the focus of therapy that can occur when disclosures are made randomly, while at the same time allowing for potential benefits that may occur when a therapist shares personal information with a client (Barrett & Berman, 2001). It is noted that reciprocal self-disclosures may also occur as a result of the therapist's countertransference, though there was no research identified that examined the use of reciprocal therapist self-disclosure.

Categories of self-disclosure. Wells (1994) additionally defined four categories of self-disclosure. The first category involves information about the therapists' credentials and training, and includes information such as where they attended graduate school, their degree/student status, and from which theoretical orientation they practice (Wells, 1994). The second category includes revelations about personal life circumstances, attitudes and experiences, which includes information about the therapist's marital status, opinions about an issue in therapy, sexual orientation and personal struggles that may or may not be similar to that of the client (Wells, 1994). The third disclosure that Wells describes is related to personal reactions to or feelings about the client that arise in therapy, such as when a therapist would comment on the client's repeated tardiness as being a problem or disclosing feelings of liking or disliking the client. Lastly, Wells' (1994) fourth category includes any admission of mistakes in therapy by the therapist, such as acknowledging saying something insensitive or inappropriate.

In the debate about the appropriateness of therapist self-disclosures, many have argued that Wells' categories highlight the distinction between within-session disclosures (third and fourth category) and those that reveal personal information about the therapist outside of sessions (first and second), which does not appear to be differentiated in much of the past research. It is also important to consider the reaction or response of the client following a self-disclosure. While disclosing could serve to strengthen the therapeutic alliance, there is also a chance that it could cause a therapeutic rupture, or a breakdown in the collaborative relationship between the client and therapist (Safran & Muran, 2006). Safran and Muran (2011) go on to say that there are several ways for a therapist to attempt to repair an alliance rupture, including acknowledging that the client may have felt criticized by something the therapist said, highlighting an example of Wells' fourth category of self-disclosure. Wachtel (1993) stated that this disparity **"virtually defines the boundary between disclosures that are acceptable and those that are not"** (p. 211). These issues are addressed in more detail in a section comprising ethical issues as related to therapist self-disclosure.

A review of the extant literature on therapist self-disclosure revealed various definitions used in past research, some of which were used for the current study.   Taking into account the most recent literature and for the purpose of this study, self-disclosing and self-involving statements can be defined as "an interaction in which the therapist reveals personal information about him/herself, and/or reveals reactions and responses to the client as they arise in the session" (Knox et al. 1997, p. 275), respectively. Self-disclosing statements can be divided into consistent and non-consistent categories and self-involving statements can also be divided into immediate and non-immediate

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categories. Furthermore, Wells' (1994) categories (i.e., demographic, personal, feelings, and mistakes) identify specific self-disclosure content that can be coded for explicitly. Lastly, reciprocal therapist self-disclosures are those that occur in direct response to client disclosures.

Countertransference and self-disclosure. Much of the original debate over the use of therapist self-disclosure from the early analytic perspective centered around the notion of countertransference, or the therapist's unintentional, unconscious, defensive response to the client's transference. From this stance, a therapist would verbally self-disclose due to his or her own unresolved issues; thus disclosing from a place of meeting his or her own needs rather than the client's. This is also known as role-reversal, where the focus of treatment unintentionally shifts from the client to the therapist (Myers & Hayes, 2006).

In addition to unintentional countertransference disclosures, therapists can make intentional countertransference disclosures (Myers & Hayes, 2006). For example, if a therapist has a personal involvement in the issue that the client is discussing (e.g., the client is having difficulties with her new marriage and the therapist is about to get married), the therapist may intentionally choose to share his/her personal countertransference towards the issue. Gelso and Hayes (2007) posit that the utilization of intentional countertransference self-disclosures may be useful if therapists are adept at managing their own anxiety that arises through the discussion of an area of personal involvement in their own lives.

In addition to verbal self-disclosures, therapists' can also either intentionally or unintentionally self-disclose aspects or characteristics about themselves through other

means, such as choosing their style of dress and deciding which magazines to put in the waiting room. Theorists have suggested that in examining their own countertransference reactions, therapists may be able to deepen their empathy for clients, develop insight, and provide hope to clients that problems can be resolved (Gorkin, 1987; Nouwen, 1972).

The literature on the effects of unintentional and intentional self-disclosure relies mostly on theoretical discussions, and includes potentially problematic and helpful results or effects on the client and the therapeutic relationship. For example, Wells (1994) notes that the therapeutic relationship may be undermined when therapists choose to intentionally self-disclose in an attempt to seek approval and validation from the client (Wells, 1994). Examples of unintentional, potentially problematic, countertransference therapist behaviors may include: overprotection, creation of a benign therapy experience, rejection, and hostility (Watkins, 1989).

On the other hand, Myers and Hayes (2003) contend that sharing countertransference reactions with clients may help to convey a sense of universality and model vulnerability and authenticity in a therapeutically beneficial way. Similarly, Safran and Muran (1996) suggested that sharing countertransference reactions by use of therapist self-disclosure may be used to repair a ruptured alliance. Other researchers advocate for the use of therapist self-disclosure of countertransference reactions when that information might confirm a client's sense of reality, intentionally offset a power imbalance, decrease the client's sense of isolation, and foster an authentic therapeutic relationship (Brown, 2001; Gorkin, 1987; Hayes & Gelso, 2001; Yeh & Hayes, 2011). Ellis (2001) similarly agreed that the discussion of countertransference provides an opportunity for rapport building and mutual learning of how to cope with common

problems. As with most therapeutic interventions, the call to intentionally self-disclose to a client is dependent on many variables unique to each individual client and therapist. Research on the use of countertransferential self-disclosure can be found below in a section examining the effects of therapist self-disclosure.

Given the debate over the use of self-disclosure as a countertransferential reaction, there is little research that systematically examines self-disclosure in this context. Because it is a difficult task to even measure the levels of intentionality in verbal or non-verbal gestures, determining whether a disclosure is countertransferential or not in nature presents unique challenges to measuring it in a systematic way. Furthermore, the effects that countertransference disclosures have on clients are an important construct, yet there is little research that focuses on them. Therefore, though difficult to measure, there is a great need for further research in this area.

Ethics of self-disclosure. The American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct (APA, 1992) offers several ethical principles and guidelines that apply to the issue of therapist self-disclosure. Ethical Standard 1.19 is one of the APA guidelines most closely related to the controversy surrounding self-disclosure. This guideline reads, "Psychologists do not exploit persons over whom they have supervisory, evaluative, or other authority such as . . . clients or patients" (APA, 1992, p. 1602). APA Ethical Principle E includes a similar statement that highlights the fact that psychologists have power over their clients and must therefore avoid using that power in an exploitative manner. Although these guidelines do not speak specifically to therapist self-disclosure, concerns have been raised in the past in regards to exploitation of clients in relation to self-disclosure. More

specifically, if/when therapist self-disclosure seeks to meet the needs of the therapist over that of the client, it would be considered by most to be unethical.

In addition to the APA's proposed ethical guidelines, Koocher and Keith-Speigel (2008) suggested that therapists also follow nine core ethical principles, which include but are not limited to: non-maleficence (doing no harm to clients) and beneficence (goal is to help others). Both principles are implicit discussions of therapist self-disclosure and its clinical usefulness because it has been demonstrated that therapist self-disclosure can both cause clients to feel both harmed and helped, depending on the study (Peterson, 2002).

Furthermore, some believe that misuse of therapist self-disclosure could mutate the therapist role beyond clinical effectiveness, perhaps resulting in role reversal (Lazarus & Zur, 2002). Gutheil and Gabbard (1993) stated that few clinicians and therapists would argue that therapist self-disclosure is always unethical, especially since it is never entirely avoidable. Therefore, the larger question then becomes what content, in what context, for what reasons and to whom is self-disclosure either appropriate or not. This again requires clinical and supervisory judgment for clinicians in training.

In regards to Wells' (1994) previously mentioned categories for self-disclosure, many have asserted that disclosures of information that is not directly related to the therapeutic encounter (or the here-and-now) may be considered unethical (Peterson, 2002). Wachtel (1993) argued that bringing his or her own experiences into therapy, the therapist is acting in a selfish manner that undermines his or her empathy and appreciation for the client's needs. Conversely, when therapists disclose reactions (whether countertransferential or not), they are demonstrating attention to the client's

current experience and appreciation for their needs above their own (Peterson, 2002). Wachtel (1993) goes as far as to say that these former types of self-disclosure are exploitative while the latter type is beneficent.

As related to Wells' (1994) categories of self-disclosure, it has also been raised that disclosures made in regards to the therapist's training and practice may be considered more ethical than those that reveal details about their personal life. Despite Epstein's (1994) strict warnings about the dangers of disclosing personal information, many argue that not providing information about a therapist's therapeutic training and practice would be unethical, and it is a question that many clients have early in treatment when rapport is not yet sufficiently established (Peterson, 2002). For example, choosing not to disclose one's own academic credentials and training experiences might result in the client not returning to therapy.

Feminist therapists in particular emphasize the necessity of therapist self-disclosure for the purpose of consumer rights and informed consent (Peterson, 2002). As described in more detail earlier, therapists practicing from a feminist perspective have advocated for more disclosure than clinicians and researchers from many other schools of thought. Brown and Walker (1994) state that clients have a right to know about their therapist's marital status, sexual orientation, political values, religion and socioeconomic background in order to determine whether they are well suited to treat them. Feminists would argue that knowing this information is important because a therapist's job is to act as a role model for their clients, and those who are more demographically similar to their client make more suitable role models (Peterson, 2002). Overall, very little is known about the ethical impact that therapist self-disclosure may have on boundaries and

professional qualities from the perspective of actual clients (Audet, 2011); rather, the ethical debate over this topic remains a fairly hypothetical one.

Self-Disclosure and the Therapeutic Relationship

It is important that therapist self-disclosure only be used to address the needs of the client rather than those of the therapist, after weighing the costs and benefits of that particular intervention with the client. However, there is a paucity of research that actually systematically explores the impact that it can have on clients. The research that does exist, though varied methodologically, tends to focus on the effect that it has on the therapeutic relationship (Audet & Everall, 2010). Despite the debate over whether therapist self-disclosure is useful or not as a way of strengthening the therapeutic relationship, both student therapists and those with more experience should continue to explore the reasons why or why not to disclose, their motivation in doing so, and the effects it has on each client.

This section focuses primarily on the effects that therapist self-disclosure has on the therapeutic relationship and treatment outcome. First, a discussion about the timing of therapist self-disclosures within the therapeutic relationship will be presented. Then, after touching on the lack of research specifically related to student therapists, it critically describes the positive, negative and mixed effects of therapist self-disclosure, and concludes with a critique of the current body of literature that explores therapist self-disclosure.

Timing of self-disclosure within the therapeutic relationship. Gibson (2012) writes that therapist self-disclosure can occur and changes across different points in the therapeutic relationship. In the beginning of the treatment process, for example, some

therapists report that they typically disclose biographical information to new clients, such as their professional training, previous experiences, and some demographic information (e.g., marital or parental status; Henretty & Levitt, 2010; Knox & Hill, 1994). Other therapists report that they use self-disclosure related to their own emotional and immediate experiences as a means to overcome or repair a rupture in the therapeutic alliance (Rabinor, 2009; Roberts, 2005; Sparks, 2009), which may occur at any time in the course of the therapeutic relationship (Gibson, 2012).

There may also be opportunities for therapists to utilize self-disclosure at the end of the therapeutic relationship. In fact, some researchers have found there to be a significant increase of therapist self-disclosure nearing termination (Henretty & Levitt, 2010). Hill and Knox (2003) state: "Therapist self-disclosures at termination may be particularly effective, and therefore we also encourage therapists to consider using this intervention as therapy ends" (p. 537). They go on to say that termination disclosures may help make the therapist appear "more real and more human" (Knox & Hill, 2003, p. 538) to the client, which can serve an important function as the two part ways. Another explanation for disclosing at treatment termination is offered by Gelso and Carter (1994), who suggest that as the client's response to information about the therapist changes over time, clients at the end of a therapeutic relationship may have more tolerance for and interest in information about their therapist as a "real" person. No studies were found that specifically examined the timing variable with student therapists, whose use of self-disclosure in general is discussed next.

Student therapists' use of self-disclosure. A recent study reports that little to no "metadiscussions" (Bottrill et al., 2010, p. 1380) about the process of supervising self-

disclosure could be found in 2009. Similarly, Weinstein, Winer, and Ornstein (2009)

reported that there was surprisingly little research available to date on the discussion of

therapist self-disclosure in supervision, contending that when these issues arise they are

likely due in part to a concern whether self-disclosure was appropriate or not.

Therapists-in-training may exhibit higher levels of uncertainty and vulnerability

when faced with opportunities for self-disclosure with their clients because of the

learning process that comes along with evaluating and applying various interventions in

session (Bottrill et al., 2010). This uncertainty may be particularly salient if a student

therapist is receiving training and supervision from individuals of multiple different

theoretical orientations and therapy styles, who may offer differing opinions and clinical

advice. Similarly, students in training are often exposed to more than one theoretical

perspective at one time or in quick succession, making it difficult for them to inform their

decision to self-disclose or not based on theory (Bottrill et al., 2010). For example, they

may have multiple supervisors who adhere to different orientations and offer different

clinical advice on the utilization of self-disclosure with clients.

Bottrill et al. (2010) studied 14 (10 women, 4 men; aged 26 to 32 years; 12

Caucasian, 1 mixed race, and 1 Asian) student therapists who were enrolled in four

different doctoral programs in psychology (with 8 in their third-year and 4 in their

second-year of training). The students expressed instances of hesitance to discuss their

own self-disclosures to their clients, if they felt their supervisor would disapprove of

doing so. This finding is consistent with research that suggests supervisees commonly

hide information from their supervisors, particularly if they perceive that they made a

mistake (Yourman & Farber, 1996). Thus, the extent to which student therapists are

accurately reporting instances of self-disclosure, both in supervision and in Bottrill's

study, is unknown. Because little is known about the effects that *student* therapist self-

disclosure has on clients in general, this section next discusses the effects of self-

disclosure pertaining to all therapists in general.

      Positive effects of therapist self-disclosure. Several studies were identified that

reported positive effects related to therapist self-disclosure. In the earliest study of

therapist self-disclosure that paired 40 participants (all women) from an undergraduate

introduction to psychology class with experimenters, Jourard and Jaffe (1970) reported a

significant, positive relationship between interviewer self-disclosure and subsequent

interviewee self-disclosure. In other words, they found a significant increase in

interviewee disclosures as the interviewers disclosed more personal information about

themselves.

      Additionally, several studies have shown appropriate therapist self-disclosures to

be efficacious from the client's perspective (Hill et al., 1989; Knox et al., 1997; Wells,

1994). In the only study located in which therapists and clients actually rated their own

disclosures, Hill et al. (1989) examined clients' (8 females; mean age = 42.38 with a

primary Axis I disorder; no ethnicity data reported) perceptions of self-disclosure and

found that the use of reassuring disclosures were rated as more helpful by clients and

therapists and led to greater client experiencing than did challenging disclosures.

Similarly, in a qualitative study of 13 clients (9 women and 4 men, all European

American) in long-term (mean = 61 months, range = 5 – 192 months) psychotherapy,

Knox et al. (1997) found that through the authors' qualitative analyses of semi-structured

interviews with the participants, clients perceived therapist self-disclosure as being

intended to normalize, reassure, and equalize clients. Also, the positive effects occurred

when therapists self-disclosed when clients were discussing issues that were of particular

importance to them, further demonstrating that Jourard's dyadic effect plays an important

role in the timing of therapist self-disclosure. Of note, the therapists' in the Knox et al.

(1997) study were instructed to make self-disclosures that involved the same antecedent;

when a client was discussing important personal issues.

 Several literature and research reviews have also found that clients view their

therapists more favorably when appropriate levels of therapist self-disclosures are utilized

in session (Hill & Knox, 2001; Mann & Murphy, 1975; Watkins, 1990), further

suggesting that therapist self-disclosure plays an important role in the development,

maintenance, and repair of the therapeutic relationship. One study which examined 116

undergraduate students' (91 women, 104 European American, mean age = 20.8, no other

demographic information included) reactions to acted-out therapeutic sessions, found that

when therapists made self-disclosures about relatively resolved issues in their own lives,

they were judged to be more attractive and trustworthy, and better at providing hope than

when they made disclosures about largely unresolved issues (Yeh & Hayes, 2011).

Therefore, it can be inferred that a client would respond more favorably towards a

statement that a therapist makes which suggests that they have already effectively dealt

with and resolved a particular issue as opposed to the issue remaining unresolved.

 Similarly, Audet and Everall (2010) conducted a qualitative study with nine

community volunteers (5 male, 4 female; 8 Caucasian, 1 Hispanic) who had received

individual therapy (ranging from 5-100 sessions) with a mental health clinician. Through

a thematic analysis of transcribed interviews, they found that clients observed therapist

self-disclosure as a key variable in the development of rapport, as it added to client comfort and made therapy seem more personable. Participants in this study emphasized how disclosures presented their therapists as "more human" (Audet & Everall, 2010, p. 339) and exposed their fallibilities, which they did not rate as detrimental or compromising to the therapeutic relationship. In fact, this finding was consistent with an older study showed that therapist who made self-disclosures about their personal vulnerabilities and shortcomings were described by their clients as more empathic, warm and credible than therapists who made self-disclosures about their professional experiences and personal skills (Hoffman-Graff, 1977). It is also similar to results from another older study that found interviewers who made an intermediate number of disclosures (4, as opposed to 0 or 12 in the other conditions), led to the interviewer being described as significantly more empathic, warm and congruent (Mann & Murphy, 1975). Of note, Mann and Murphy (1975) noted that the timing of interviewer disclosures had no effect and did not contribute to study outcomes.

In regards to symptomatology, Barrett and Berman (2001) examined 36 individuals (15 men and 21 women, mean age = 27, ethnicities withheld) receiving outpatient psychotherapy, who reported initial levels of symptom distress that were comparable with normative depressed or anxious outpatient groups. Results indicated that clients who were paired with therapists who were instructed to heighten their use of self-disclosure reported lower levels of symptoms distress and tended to like their therapists more than clients who were paired with therapists who were instructed to refrain from using self-disclosure. This finding lent preliminary evidence to suggest that heightened therapist self-disclosure may have a positive impact on the therapeutic

relationship and treatment outcome. Because their study included only instances of reciprocal self-disclosure, self-disclosures that are unrelated to client concerns or are not made in response to a client disclosure may produce different, less positive outcomes that their study indicates.

Negative effects of therapist self-disclosure. Little is known about the effects of unhelpful or inappropriate therapist self-disclosure on clients, given that it would likely be considered unethical by some to conduct studies in which harm could be caused to real clients. Instead, much of the research discussed in this section on negative effects was found using procedures including written dialogues and analogue methodology. One study utilizing actual therapy clients was found and is discussed in more detail.

One of the early studies of self-disclosure examined written dialogues that were administered to fifty-seven participants (29 men and 28 women, no other demographic information provided) with a mean age of 32 who were receiving psychotherapy from a metropolitan mental health center (Curtis, 1981). They were randomly assigned to read vignettes created by researchers from one of the three treatment conditions: high, low, and no self-disclosure (Curtis, 1981). This study found that high therapist self-disclosure adversely affected clients' perceptions of empathy, competence, and trust in the therapist in the dialogue. The findings of negative effects stood in direct opposition to what humanistic theorists postulated in years prior and in later research studies (Hill & Knox, 2001). One explanation for Curtis' results was that it did not examine the dyadic effect that Jourard discussed in his 1971 work and that Barrett and Berman (2001) refer to as reciprocal self-disclosure, in which clients' self-disclosures were considered the dependent variable.

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Therapist self-disclosures in Curtis' (1981) investigation were not made in response to client self-disclosures, the basis on which humanists support the use of the technique. Barrett and Berman (2001) contend that despite the presumed psychoanalytic risk of taking the focus off of the client, reciprocal self-disclosure could actually serve to limit or reduce disruption in the focus of therapy and highlight the present moment. Therefore, research that does not examine the relationship between client self-disclosure and therapist self-disclosure may be limited; however, much of this debate remains a theoretical argument and has yet to be tested from this perspective.

A more recent qualitative study, with 9 participants (5 male, 4 female; mean age = 35.7; 8 Caucasian, 1 Latino) found through open-ended interviews with participants that the risks that are most commonly associated with the use of therapist self-disclosure are that providing personal information about oneself can blur client-therapist boundaries and decrease potential professional roles that are associated with being a therapist (Audet, 2011). As noted earlier, however, very little research other than the aforementioned study has examined whether these negative effects are the case for real clients or whether this is speculation that has arisen from research and studies utilizing analogue methodology rather than actual therapy sessions.

Mixed effects of therapist self-disclosure. The majority of the scant research on self-disclosure in therapy has found mixed effects. This subsection presents several studies with findings that suggest that there are a variety of effects of therapist self-disclosure, including both positive and negative within each study.

First, Wells (1994) found mixed effects of therapist self-disclosure, with the positives including increased mutuality and validation of client (demographic information

not available) experience, as well as positive perceptions of the therapist as being more involved, trusting and understanding than in instances of no self-disclosure. At the same time, clients involved in this study reported feelings burdened by the disclosure, less trusting of their therapists' competence, and less likely to bring up certain issues in order to protect their therapists' feelings (Wells, 1994).

Nearly twenty years later, Audet (2011) qualitatively examined transcripts from interviews with nine different clients (5 male, 4 female; mean age = 35.7; 8 Caucasian, 1 Latino) about their perceptions of boundaries and professionalism in the context of receiving non-immediate personal disclosures. Using content and thematic analysis of transcribed open-ended interviews with the participants, they found mixed results: therapist non-immediate self-disclosures can, but do not necessarily, cause boundary transgressions; they can enhance or diminish perceived professionalism and competence; and they can enhance or compromise the client's view of client and therapist roles (Audet, 2011). As these findings raise ethical issues, there is a need for more in-depth qualitative explorations of actual therapist-client encounters.

Other research has examined the impact of therapist self-disclosure on the client's perspective of their therapist's competence and boundaries. Several studies have found that low-disclosing therapists and therapists who use self-involving statements are rated as more expert by their clients than high-disclosing therapists or those who disclosed personal information to their clients (McCarthy, 1979; Merluzzi, Banikiotes, & Missbach, 1978; Myers & Hayes, 2006). These studies are limited because they were based on observer ratings of brief mock therapy sessions with non-clients (Audet, 2011). Yet, qualitative studies using actual therapeutic encounters have demonstrated mixed results.

Wells (1994) found that approximately half of the clients in his study reported that disclosures altered boundaries so that the client viewed therapists in a more negative way, leading to reduced credibility and decreased confidence in the therapist's abilities. Conversely, Knox et al.'s (1997) study found that helpful therapist self-disclosure (i.e., that occurred during the discussion of important personal issues, that were perceived in an attempt to normalize/reassure, and consisted of personal non-immediate information about the therapist) had an equalizing effect on clients, making the therapist appear more imperfect and thus more similar to the client (Knox et al., 1997). Because it is possible that this change in boundary could lead to a reduction in credibility, assuming a therapist-client power differential, future research in this area is warranted.

To date, it appears that only two articles have been published which examine the relationship between therapist self-disclosure and countertransference (Myers & Hayes, 2006; Yeh & Hayes, 2011). In the first study, participants perceived sessions as shallower and the therapist as less expert, as measured by the Counselor Rating Form (CRF; Barak & LaCross, 1975), when the therapist made either general disclosures or countertransference disclosures as opposed to no disclosures (Myers & Hayes, 2006). In the second study, which utilized the same scripts as the aforementioned study, the type of therapist self-disclosure did not affect ratings of the expertness of the therapist, the depth or smoothness of the session, or the perceived universality between the client and therapist, again demonstrating mixed results (Yeh & Hayes, 2011). Given that both of these studies involved analogue methodologies with non-clients, further investigation is needed in this area utilizing actual therapy sessions and client data.

Critique of research on self-disclosure. Coupled with the abundance of mixed findings that have come out of research on therapist self-disclosure, nearly all previous research that examined the use of therapist self-disclosure as related to the therapeutic relationship is further limited because of its analogue nature (Bottrill et al., 1991). When scripts written by researchers rather than actual therapy sessions between a therapist and a client are used to generate findings, then results may not be accurate or representative of how a client feels about therapist self-disclosure in actual therapeutic scenarios. While other forms of methods have been used, the varied methodology used in previous research, as well as small, homogeneous samples also limits comparison and generalizations across studies. Additionally, no studies appear to systematically examine each of the various forms of self-disclosure (e.g., immediate vs. non-immediate, positive vs. negative, self-disclosing vs. self-involving, consistent vs. inconsistent) in conjunction with one another.

The studies just reviewed showed that clients experience an array of impacts stemming from even a single therapist disclosure (Audet & Everall, 2010; Knox et al., 1997; Wells, 1994). However, there are limitations in the way the impact of self-disclosure has been measured in the research thus far. As a result, it is difficult and perhaps limiting to attribute a wholly positive or negative label to the client's experience of self-disclosure.

Thus, given the mixed and limited results that have stemmed from the current body of research on therapist self-disclosure, Bottrill et al. (2010) point out that the use of this complex therapeutic technique requires and emphasizes therapist reflection on the utility and motivation behind their use of it with clients. They further assert that although

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it is impossible to generate rules and guidelines that are applicable to every therapeutic

encounter, therapists should remain aware of the impact that it has on their clients and on

the therapeutic relationship as a whole. Because the nature of therapy itself is

spontaneous, it is not always possible to anticipate the use of therapist self-disclosure

prior to a session; rather, it might be more useful for a therapist to develop a general way

of responding to requests or opportunities for disclosure (Goldstein, 1997), which is a

dynamic construct that may develop and change over time through reflection.

Finally, relatively little research has focused on the therapist's perspective of self-

disclosure, or comparing therapist and client perceptions and outcomes. Bottrill et al.

(2010) reported that previous research found the reasons why a therapist may choose to

self-disclose, which included strengthening the therapeutic relationship, normalizing

client experiences, and pointing out alternative ways of thinking (Mathews, 1988; Simon,

1988). Alternately, therapists may self-disclose unintentionally or as a result of

countertransference, which some theorists argue may be in response to serving their own

needs above the client's. Hill et al. (1989) additionally found that therapists rated their

disclosures as less helpful than their clients rated them, which is consistent with theory

that postulates that that therapists may, like their clients, experience a wide range of

emotions when disclosing aspects about themselves (Farber, 2006). Hill et al. (1997)

speculated that therapists themselves may feel unsure about revealing personal

information, the perceived impact of their disclosure, as well as uneasy about a shifting

power dynamic within the therapeutic relationship. Furthermore, self-disclosure can be

particularly difficult for therapists in training, as they are just beginning to implement

effective interventions and are exposed to a wide variety of training models and theoretical orientations (Bottrill et al., 2010).

Self-Disclosure and Trauma Treatment

Approximately one-third of therapists and therapists-in-training who specialize in the area of trauma have trauma histories themselves, which may influence the way in which they feel and react to trauma disclosures and discussions (Pope & Feldman-Summers, 1992). Studies also have demonstrated that therapists who have trauma histories tend to experience greater secondary traumatic stress than therapists who do not have trauma histories (Ghahramanlou & Brodbeck, 2000; Pearlman & Mac Ian, 1995; Stevens & Higgins, 2002). Although research has shown the various ways in which vicarious traumatization negatively affects trainee therapists (Adams & Riggs, 2008; Hesse, 2002; Killian, 2008; Wood, 2012), little is known about its effects on the therapeutic relationship, including therapists' use of self-disclosure. Of note, no studies in the existing literature were identified that examined the timing of self-disclosure with clients who are in trauma treatment.

This subsection explores the impact of therapist self-disclosure when used during treatment that focuses on trauma, as defined by the DSM-5 and the present study. First, the reasons for and against the use of therapist self-disclosure in trauma treatment are presented. The reasons for self-disclosure include: as a means to share countertransferential reactions, as an attempt to strengthen the relationship with trauma survivors, and as a means to change their neuropsychological patterns. Conversely, some of the reasons cited against therapist self-disclosure include: issues with professional boundaries, vulnerability of therapists and trauma survivors, therapist

confusion about motives for self-disclosure, and ambiguity about whether self-disclosure will benefit or impede work with clients. Next, some guidelines for the use of therapist self-disclosure are presented, including the ethics of its use with clients. Lastly, research findings will be presented as related to the use of therapist self-disclosure in trauma treatment, specifically.

      Reasons for and against self-disclosure in trauma treatment. Researchers and theorists have posited a variety of reasons why a therapist might choose to self-disclose in working with trauma survivors in particular. This subsection discusses reasons related to boundaries as well as other reasons for self-disclosure, which include: increasing connection, balancing power, instilling hope, affirming feelings, validating their self-worth, aligning with the client, and strengthening the therapeutic relationship. The section ends with a discussion of the neurobiological benefits of self-disclosure.

      First, therapists working with trauma survivors should attempt to define clear boundaries at the outset of treatment and address any transgressions that may occur over the course of treatment. Harper and Steadman (2003) posited that maintaining boundaries with sexually abused clients is critical to the development of an emotionally and physically safe and trusting therapeutic relationship. Similarly, other authors believe that therapist self-disclosure can be a useful tool to use with childhood sexual abuse survivors because it can be an instructive tool and a means of fostering trust and intimacy within the therapeutic relationship, which is particularly salient with trauma survivors (Pearlman & Saakvitne, 1995; Smith & Fitzpatrick, 1995).

      Consistent with these beliefs, two studies found that therapists commonly disclosed personal background information to sexual abuse survivors in order to connect

to them, to balance power, and to instill hope (Fehr, 2010; Harper & Steadman, 2003). Harper and Steadman (2003) obtained their results from questionnaire responses and videotaped interviews of 14 therapists (7 group, 7 individual therapists; no other demographic information provided) who had provided treatment to sexual abuse survivors; the therapists in their study included social workers, child and youth workers, shelter workers, nurses, probation officers, and crisis hotline volunteers who had worked with sexual abuse victims.

In addition, therapists may choose to self-disclose to victims of sexual abuse in order to affirm the client's feelings of anger or sadness, reinforce genuineness and validate their sense of worth, and provide valuable information about how to respond to the difficulties he or she is facing (Knight, 1997). Therapists may choose to self-disclose as a means of strengthening the therapeutic relationship and aligning with the client, providing a context for which the therapist can understand what the client is going through. For example, past studies demonstrate that homicide survivors feel more comfortable discussing the death of a family member only with someone who has experienced a similar event (Masters, Friedman, & Getzel, 1988). Similarly, research that has demonstrated that victims of domestic violence tend to report higher levels of satisfaction with their therapeutic experience when their therapist either discloses or denies having experienced intimate partner violence at some point in time (LaPorte et al., 2010). This finding would suggest that regardless of whether or not the therapists had experienced victimization themselves, the act of telling the client either way is a powerful tool that can be considered in working with domestic violence survivors.

Lastly, Quillman (2011) investigated therapist self-disclosure as a means to increase a client's right-to-right brain communication, which is believed to deepen the client's capacity for self-regulation and is considered the core of therapeutic change (Schore, 2003, 2007). This theory is similar to Levine's (2007) work on utilization of a bottom-up approach in the right hemisphere to increase affect regulation in individuals who had experienced trauma. Quillman (2011) hypothesized that therapist self-disclosure (of here-and-now-interactions) would provide a deepened sense of connection between the therapist and the client, making explicit what the implicit system is picking up by the therapist. He also posits that therapist self-disclosure is particularly important in: (a) decreasing client anxiety about negative affect, (b) helping the client to discover that negative affect is not only less dangerous than originally feared, but can lead to a greater sense of connection and safety, and (c) increasing the power of positive affect for self-regulation and reconfiguring the client's internal world. Because individuals who have experienced trauma have been shown to have lower levels of affect regulation than those who have not (Bardeen & Read, 2010; Briere, Hodges, & Godbout, 2010; Chen, Huang, Dang, & Zheng, 2012; Schore, 2009), this theory supports the idea that therapist self-disclosures of an affective nature may be an appropriate intervention with trauma survivors who display affect dysregulation.

While therapist self-disclosure may have positive effects on clients who have experienced trauma, there has been research that has shown that some therapists who treat trauma survivors do not see it as a useful therapeutic tool. In the Laporte et al. (2010) study, respondents who indicated that therapist self-disclosure was not helpful as a therapeutic tool had two main concerns: (a) that clinicians working in crisis situations

need to maintain professional boundaries in order to provide a safe environment for survivors, and (b) therapists need to be aware of the levels of client vulnerability. The authors go on to say that because of the nature of traumatic events and the fact that these clients are particularly vulnerable, hearing therapists make a disclosure about their own experiences may exacerbate clients' already high anxiety levels. In fact, some respondents in this study were adamant that therapist self-disclosure is never appropriate and is unprofessional to do.

Finally, Seely's (2008) study examined some of the reasons why therapists may feel uncertain about using self-disclosure after having been in the same disaster as their clients. These included: (a) experiencing confusion about their motives for self-disclosure, (b) ambiguity over whether their self-disclosure of personal information with help or impede their work with clients, and (c) feeling uncertain about how clients may experience their vulnerability (Seely, 2008).

Research findings related to self-disclosure in trauma treatment. Although less research is readily available on the use of self-disclosure with clients who have experienced trauma, preliminary literature suggests that there are certain considerations (e.g., boundaries, nature of trauma) that should be taken into account, specifically for this population. Accordingly, constructs and implications that come from research on using self-disclosure with trauma survivors to be discussed in this subsection include boundaries, culturally sensitive and therapeutically appropriate interventions, and normalization of their traumatic experience.

One study that examined self-disclosure during the treatment of individuals who have experienced sexual abuse discussed the importance of the maintenance of

boundaries when working with this population (Harper & Steadman, 2003). In this particular study, participants included male and female (no specific demographic information included) therapists who had worked in the area of childhood sexual abuse for at least two years. Therapists completed written questionnaires that explored specific boundaries, such as self-disclosure, physical contact, and gift-giving, and audiotaped interviews with the researchers regarding therapist self-disclosure. Common reasons given for therapist self-disclosure were therapist anxiety about survivor safety, feelings of resentment towards the survivor for disclosing and wanting to connect, give hope, and balance power in therapy. The authors speculated that due to the nature of their trauma (i.e., childhood sexual abuse), the therapists struggled with knowing how to form appropriate boundaries themselves (Harper & Steadman, 2003). No studies were identified that examined or measured when vicarious traumatization occurred within the context of trauma treatment.

Other literature has expanded on similar themes (shame, trust, countertransference, and boundaries) as relevant to LGBT survivors of childhood sexual abuse (CSA; Russell, Jones, Barclay, & Anderson, 2008) and adult survivors of childhood incest (Rybowski, 1996), even though they did not examine therapist self-disclosure. The former review of literature, which looked specifically at the experience of LGBT CSA survivors and the themes that are of particular salience for that population (e.g., transference/countertransference, developmental issues, boundaries), reinforced the importance of providing treatment that is culturally sensitive and therapeutically appropriate (Russell, et al., 2008). For example, Russell et al. (2008) identified several clinical issues for consideration that may arise during treatment with this population,

including mistrust, acting out, need for limit setting, false self-presentations, and shame. In the latter study, 168 psychotherapists completed an author-made instrument (The Therapist Questionnaire) that addressed countertransference reactions and boundary management with therapists working with adult incest survivors, which revealed both over-involvement and distancing from the patients (Rybowski, 1996).

Guidelines for self-disclosure in trauma treatment. Both overall and when working with individuals who have experienced a traumatic event at some point in their lives, there are several guidelines found in the literature related to therapist self-disclosure that directly affect the therapeutic relationship. These include: (a) be clear about why self-disclosure is used; (b) remain mindful of the content and impact of the intention; (c) fit the disclosure to the client's needs; (d) self-disclose infrequently and judiciously; (e) maintain appropriate boundaries; (f) consider your own motivation for disclosing; (g) and ask clients about their response to the disclosure (Goldfried et al., 2003; Knox & Hill, 2003; Strickler, 2003). For therapists in training, supervision or consultation with a licensed psychologist is strongly advised.

In keeping with these guidelines, therapists need to display caution when using self-disclosure with clients who have experienced trauma. Therapists should display caution when self-disclosing a history of trauma as they may mistakenly assume that they will understand the client's reaction based on his/her own personal experience; it should therefore be considered an optional intervention (Tosone, Nuttman-Shwartz, & Stephens, 2012). Also, therapist self-disclosure may place clients in a caretaker role, which is at times all-too-familiar with individuals who were sexually abused (Knight, 1997).

Purpose of the Study and Research Questions

Therapist self-disclosure has been a long-debated topic that has sparked controversy across theoretical orientations, but is under-explored in research. The studies that do exist reveal mixed effects of self-disclosure on variables related to the therapeutic relationship, and are limited methodologically in using analogue research methods with mock clients. Additionally, little is known about its use by student therapists who are early in their training, particularly those treating clients who have experienced trauma.

As a result of these limitations, this study sought to better understand and explore trainee therapists' use of self-disclosure with clients who have experienced trauma. Accordingly, this study used qualitative analyses in order to systematically explore trainee therapists' use of self-disclosure in trauma treatment utilizing videotaped therapy sessions of trainee therapists' and their clients. The specific research question was as follows: How do trainee therapists use self-disclosure with clients who have experienced trauma?

Chapter II: Method

The present study involved a qualitative analysis of the use of therapist self-disclosure in psychotherapy with clients who have experienced trauma. To accomplish this goal, this chapter provides a description of the methods that were used for the study, including the research design and rationale, participants, data collection, coding (see Appendix A), and analysis procedures.

Research Design

Qualitative research is useful when one wishes to understand the "How" or "What" of a particular variable instead of "Why" (Morrow, 2007). It is most commonly used in clinical or counseling psychology research because it is similar to the models and methods that are evident in clinical practice (Mertens, 2009). It is also appropriate to use when one wishes to understand the context in which participants face concerns or dilemmas or how they make meaning out of specific situations, when exploring under-researched areas, and when trying to more accurately explain existing theories that do not fully explain the variables in question (Creswell, 2007, 2009; Glazer & Stein, 2010; Morrow, 2007). The present study aimed to investigate ways in which trainee therapists use self-disclosure with clients who have experienced trauma, which has not been sufficiently explored in previous research with real clients.

Qualitative methods are also useful when trying to understand a problem or issue within a clinical context and within the therapist-client relationship (Mertens, 2009). This qualitative method of inquiry can be used to better understand multiple and complex forces and variables that influence different types of therapy and their effectiveness with clients (Mertens, 2009). Therefore, the present study used a clinical research design as

the method of inquiry in investigating trainee therapist use of self-disclosure in trauma treatment.

Furthermore, a treatment process approach was used to develop and guide the present research study. This approach is commonly used to name, describe, classify and quantify specific behaviors of both the therapist and client, and can be divided into a number of categories (Stiles, Honos-Webb, & Knobloch, 1999). These categories include:

(a) size of the scoring unit, such as single words, phrases, topic episodes, timed intervals of various durations, whole sessions, phases of treatment, whole treatment, and series of treatments, (b) perspective, or view point of the therapist/client, (c) data format and access strategy, such as transcripts, session notes, and audio/videotapes, (d) measure format, such as coding used to classify data into nominal categories, rating, or Q-sort, (e) level of inference, distinguishing the *classical strategy* in which only observable behavior is coded, from the *pragmatic strategy* in which the coders or raters make inferences about the speaker's thoughts, feelings, intensions, or motivations based on the observed behavior, (f) theoretical orientation, ranging from specific orientations to broader applicability, (g) treatment modality, such as individual adult, child, family, group therapy, (h) target person, including the therapist, client, dyad, family, or group as the focus of measurement, (i) communication channel, such as verbal, paralinguistic, or kinetic, and (j) dimension of verbal coding measures, including *content categories* which describe semantic meaning (e.g., "fear"), *speech act categories* which concern the manner in which the speech was conveyed (e.g.,

reflections, interpretations, questions, and self-disclosures), and *paralinguistic*

measures which describe behaviors that are not verbal but accompany speech

(e.g., hesitations and tonal qualities). (Stiles et al., 1999, pp. 389-390)

The specific topic in question or variable being investigated informs the choice of

measure used in the treatment process approach (Stiles et al., 1999).

After the application of these categories that describe the treatment process

approach, measures can be reported directly through case studies or intensive analyses of

brief segments of therapy sessions. However, more often these measures are

accumulated across some area of treatment or identified summarizing unit (Stiles et al.,

2009). Using this approach, one can then quantify and describe the percentage or

frequency of a particular category within each session, or across the full course of

treatment (Stiles et al., 2009). A description of how the treatment process approach was

applied in this particular study, including descriptions of the measures or categories and

how they were reported is described in more detail in the following sections.

Participants

Client-participants. Purposeful sampling was used to select five psychotherapy

cases from an archival database of videotaped sessions at a Southern California

University community counseling center. First, approval was sought from the

Institutional Review Board (IRB) from the researcher's university. All potential client-

participants must have provided informed consent to include their videotaped

sessions/written materials in the university database prior to receiving psychotherapy

services. All client materials were redacted and de-identified prior to being placed in the

archival database, so that names, date(s) of birth, and exact locations are unavailable and

clients cannot be identified. This information was kept organized on the participant

tracking sheet (see Appendix F). Table 1 provides a summary of the demographic

information for each of the client-participants.

Table 3

Client-Participant Demographic Information

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

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

Therapist-participants. Similarly, all therapists (master's or doctoral level

psychology students) consented to both written and audio/video recording procedures

(see Appendix H), and their inclusion in the archival database. All therapist materials

were redacted and de-identified prior to being placed in the archival database, so that names, date(s) of birth, and exact locations were unavailable and therapists could not be identified. Individual research files were each given a unique code to maintain organization throughout the database. Given the nature of the information collected in the archival database, Therapist-Participant gender was the only demographic information included in the present study; there was no other Therapist-Participant demographic information available to the researchers.

In order for both clients and therapists to be selected for the present study, inclusion and exclusion criteria were formed. To be considered for inclusion in the present study, all participants had to be English-speaking and at least 18 years of age at the time of intake. As previously mentioned, both clients and therapists had to give informed consent to have their written materials and audio/video procedures included in the database. Only cases with sufficient data were included, which is defined as at least one videotaped session in which a client discussed a traumatic experience with a trainee therapist. Additionally, their records must have contained a Client Information Adult form (see Appendix B), an Intake Evaluation Summary (see Appendix C), a written Intake Summary (see Appendix D), as well as a Treatment Summary (see Appendix E), within which it was indicated that the client experienced trauma.

There were two exclusion criteria in the present study. The first was that the therapists of the participants were required to be individuals that the researchers did not have a close, personal relationship with, outside of clinical and academic activities that are required of their doctoral program in psychology. This criterion was followed in the interest of maintaining confidentiality of both therapists and participants, as well as

reducing possible coding biases. Also, only individuals who were seeking individual psychotherapy were included in the sample; individuals in couples/family therapy and persons under 18 (children/adolescents) were not included in the study sample. There were no exclusion criteria as related to gender, ethnicity, religious affiliation, or socioeconomic status of either participants or therapists.

Researcher-participants. The researchers in the current study consisted of three clinical psychology doctoral students who coded the collected data (Coders 1, 2, and 3), and one auditor. The auditor is a clinical psychologist who supervised the research team through the data collection, coding, and analysis phases, including the present study. The inclusion of several researchers provided an opportunity for multiple perspectives and opinions, adding to the complexity of the data collected and limiting the individual biases of any one person (Hill, Thompson, & Williams, 1997). Coders 1, 2, and 3 independently examined and categorized codes before meeting as a group to determine a consensus. What follows is a personal description (e.g., theoretical orientation, demographics, professional views) provided by each of the coders and the auditor of the study, in an effort to determine potential areas of bias.

Coder 1, the primary researcher and dissertation author, is a 29-year-old female of German/Yugoslavian and Irish descent and a fourth-year doctoral student in clinical psychology. She was raised in the northeastern part of the United States in an upper-middle class family. Coder 1 primarily conceptualizes and treats clients from a cognitive-behavioral approach, and she incorporates strengths-based and mindfulness approaches in her work with clients. She is a supporter of evidence-based treatments and has a particular interest in working with children and adolescents who have experienced

trauma as an opportunity to therapeutically intervene early in one's lifespan. Coder 1 views and values the interaction between thoughts, feelings and behaviors as highly significant in the human experience and believes that enduring change occurs as the result of identifying, evaluating, and modifying biased cognitions and perceptions of oneself, others and the world. Coder 1 seeks to build strong rapport with her clients and use strengths-based approaches and believes that this is the foundation of an adaptive and positive therapeutic relationship, which she believes is essential when working with individuals. As it pertains to this dissertation, Coder 1 believes that the therapeutic alliance is an important aspect of client/therapist relationships and that these relationships likely change and develop based on the reactions of the trainee therapists. In particular, she is curious about student therapists' use of self-disclosure in trauma treatment, both generally and as a response to client self-disclosure.

Coder 2 is a 27-year-old, Caucasian, female clinical psychology doctoral student. She was born and raised in a middle-class family in the northeastern part of the United States. Coder 2 generally conceptualizes and treats clients, from an integrative perspective, including both relational, positive psychology, and cognitive-behavioral techniques. More specifically, she believes that the identification and modification of various levels of thought, rapport and empathy in the relationship, and a strong therapeutic alliance in therapy will contribute to improvements in mood and behavior. Consistent with this perspective, Coder 2 also views the therapeutic relationship and a sense of authenticity as necessary elements upon which such change can occur and believes that a positive reaction to a discussion of trauma, when expressed in a genuine and benevolent manner, has an incredible capacity to foster relationships and relieve

distress. She thus views the reaction of the trainee therapist as a powerful means of human connection as well as a method by which one can promote posttraumatic growth. Although the general benefits of positive reactions to disclosure of trauma are almost universally recognized, Coder 2 is particularly interested in the potential advantages of use of positive reactions to disclosure in facing stressors and trauma. She believes that therapist self-disclosure can be used as an important means of aligning with the client and tends to use self-involving statements in her work with clients.

Coder 3 is a 28-year-old Caucasian female doctoral student in clinical psychology and was raised in a middle class home in the western United States. Generally, Coder 3 conceptualizes clients and clinical cases from humanistic/existential as well as cognitive-behavioral perspectives. She conceptualizes a client as someone generally driven toward personal growth while navigating core, existential dilemmas. She strongly believes in the human potential for growth beyond that of simple symptom reduction and is encouraged by therapies and theoretical frameworks that foster such growth through illuminating meaning in the human condition. Coder 3 is especially interested in the various strategies clients use to cope or achieve personal growth in the aftermath of trauma. Coder 3 believes that self-disclosure can be useful in building rapport and as a therapeutic intervention, particularly with adolescents and young adults.

The auditor and dissertation chair for this study is a Christian, European-American, married female with both a doctoral degree in clinical psychology and a terminal law degree. She is a tenured, associate professor of clinical psychology with research and clinical interests in positive and forensic psychology. She also teaches, mentors, and engages in collaborative and independent research with students, including

9-12 dissertations students per year and with colleagues. She supports evidence-based treatments and conceptualizes clients primarily from a cognitive-behavioral perspective, although she also incorporates systems, strength-based approaches, and positive psychology approaches into her treatment. Moreover, she believes that the response of the therapist can assist individuals who have experienced trauma, including those who share such experiences in psychotherapy, in examining their experiences from different perspectives, which in some cases can lead to resilience and growth. She anticipates that trainee therapists may use self-disclosure more often than she would with clients who have experienced trauma.

Instrumentation

In order to explore and examine trainee therapists' use of self-disclosure during the discussion of trauma in psychotherapy sessions, the primary researcher created a deductive coding system through which therapist-participant behavior was classified. For the purposes of this study, client-participant behavior and reactions to therapist self-disclosure were not coded, as the focus of this study was to analyze trainee therapists' use of self-disclosure during therapy with clients who have experienced trauma. The coding system was created from an in-depth analysis of the literature on self-disclosure.

For the purposes of this study, self-disclosure was defined as verbal statements through which therapists communicate information about themselves to their clients (Hill & Knox, 2002) in two main categories: self-disclosing statements (SDIS) and self-involving statements (SINV). These two main categories were further divided into subcategories, as described below. For the purposes of this dissertation and the coding of therapist self-disclosure verbalizations, statements that contained more than one type of

code were coded into their respective coding categories, making the coding system non-mutually exclusive. It is believed that this method of coding ensured the richest possible data pool for analyses, while allowing for overlaps in verbalizations. The following operational definitions were used to create a coding system with the intent to record trainee therapist use of self-disclosure during the discussion of trauma in psychotherapy based on the above categories.

Self-Disclosing statements. Self-disclosing statements referred to when a therapist revealed any detail or theme of the therapist's life, including personal demographic information or facts about him or herself to the client (SDIS-DEMO; i.e., age, ethnicity, religious/spiritual affiliation, sexual orientation, marital status, professional credentials; "I'm in my third year in a doctoral program in clinical psychology"), and/or personal experiences or values, beliefs, and life circumstances (SDIS-PERS; i.e., hobbies, leisure activities, trauma history, medical illness, death in family, personal discrimination, political beliefs, relationship history, experiences in the mental health field; "Yes, I heard about that on the news, too," "I had to cancel our last session because my son was sick and I couldn't find a babysitter; "Audet & Everall, 2010; Wells, 1994). For the purpose of this study, self-disclosing statements were defined only by the aforementioned examples, in accordance with definitions in the current body of research on self-disclosure. It was anticipated that there may have also been self-disclosing or self-revealing statements that did not fit into either of the aforementioned categories (NOS/OTHER; "I'm hungry/thirsty," and "Actually, I cut my hair three weeks ago").

Consistent self-disclosing statements (SDIS-CON) were defined by Robitschek and McCarthy (1991) as "expressions by the counselor about his or her past which is consistent with the self-experience of the client" (p. 218). Therefore, a therapist who was utilizing consistent self-disclosure in therapy would reveal information about him or herself that was similar to that of the client. As noted earlier, these consistent self-disclosing statements could be applied to both demographic (SDIS-DEMO-CON) and personal (SDIS-PERS-CON) disclosures (Wells, 1994). Examples of these codes included, "I'm also working on my doctorate" and "I felt some of the same things when I was going through a death in my family," respectively. It was also anticipated that therapists may make reciprocal statements that are neither demographic nor personal in nature (NOS/Other; e.g., "I hope you have a great weekend, too").

Inconsistent self-disclosing statements (SDIS-INC) referred to "aspects of the therapist's past, [present, and future] that were not consistent with the client's response" (Robitschek & McCarthy, 1991, p. 218). Likewise, these negative statements could be applied to both demographic (SDIS-DEMO-INC; e.g., "No, I don't have kids [client does have children]") and personal (SDIS-PERS-INC; e.g., "I haven't struggled with drug addiction myself and can only imagine what you're going through") disclosures by therapists. Additionally, therapists may have made inconsistent self-disclosing statements that are neither demographic nor personal in nature (NOS/Other; e.g., I actually like the overcast weather [when client made a statement about not liking the weather]").

Self-involving statements. Also known as immediacy (although can be non-immediate) or countertransference statements (although SDIS can be made as a result of

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countertransference), self-involving disclosures occurred when the therapist revealed thoughts or feelings about the therapeutic relationship or the client (Bottrill et al., 2010; Knox & Hill, 2001). These statements maintain focus on the *client* and/or the therapist's personal reaction to the client as experienced within the context of the therapy session or the course of treatment. According to Peterson (2002), these statements differ from the above-mentioned self-disclosing statements because the focus or goal of them is to provide another perspective and point out interpersonal patterns, both as related to the client's issues. However, it should be noted that although Peterson uses these examples as a means of differentiating self-involving statements from self-disclosing statements, an argument can be made that self-disclosing statements may also be used to provide alternate perspectives and point out patterns of an interpersonal nature. Therefore, there are limitations to the ways in which authors have presented the various forms of self-disclosure, which is particularly salient for the present qualitative study. As such, the present study focused less on the intention of self-disclosure and more on differentiating between the different categories of therapist self-disclosure that were verbally expressed. In the present study, self-involving statements (SINV-PERS) were coded when therapist verbalizations of self-disclosure included personal feelings, thoughts, and reactions that occurred in and about the therapy session (e.g., "I understand what you mean," "I remember you told me once," and "Let's talk about that").

The other subcategory included verbalizations that involved any admission of a mistake by the therapist (e.g., "You're right, I may have jumped to a conclusion too quickly, "I'm sorry for being late to therapy" and "Yes, maybe you're right and I misunderstood what you were trying to tell me;" "I mean, I was only two minutes late.")

(Wells, 1994). Additionally, therapist responses included statements that were neither consistent nor inconsistent in nature, yet were still self-involving (NOS/Other, e.g.; "I notice you got a haircut" or "I'm wondering if you're okay?")

Procedure

       Sample selection. A purposive sampling method (Creswell, 1998; Mertens, 2009) was used to choose participants in this process. The coders of this study reviewed the list of pre-screened cases with transcribed sessions (those that have been used in former PARC research teams), and determined that all five cases met criteria for study inclusion (See Step 1 of Coding Manual). Because all five pre-screened cases met inclusion criteria for the present study, Steps 2-4 as described in the preliminary proposal for this study were not completed.

       Coding. The three doctoral students described earlier served as the primary coders for the current study. Prior to coding actual transcribed sessions, the researchers engaged in practice coding sessions with a goal of reaching 66% agreement (two of three coders in agreement), which is the highest possible rate of agreement short of unanimous. This is fairly consistent with research that shows an 80% agreement is appropriate for a study of this kind (Miles & Huberman, 1994). All coders were trained in relevant concepts and specific coding processes as related to the present study and trainee therapists' use of self-disclosure during the discussion of trauma in session.
After all three students reached a consensus on codes, the codes were then audited by their research/dissertation supervisor, with a goal of reaching 75% agreement (three of four coders in agreement).

Human subjects/ethical considerations. The researchers involved in this study were committed to protecting the rights of the therapist and client participants, maintaining ethical standards and confidentiality, and utilizing non-invasive methodology (i.e., having no direct contact with participants and using an archival database). The researchers took further precautions to maintain a high standard of ethical practices, including reviewing informed consent (see Appendix G) forms and making sure that all client- and therapist-participants in the study consented to written, audio, and video materials for inclusion in the database. These materials and files were created once therapy terminated. Following termination, a research assistant created a redacted, de-identified research file for each chart in order to ensure confidentiality for all participants before entering their information into the database. For identification and organizational purposes, all participants were given a research identification code.

Each researcher, coder, and transcriber involved in the present study completed an IRB certification course as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) online training (see Appendix I). Researchers also signed confidentiality agreements to ensure that any participant data or sensitive data was and is kept confidential. Lastly, the researchers took steps to ensure that there were no dual relationships between the researchers and the study participants (i.e., the coders did not have personal relationships with any of the clients or therapists used in the study).

Data Analysis

For the purpose of this study, a clinical research design, which was developed with the intent of assisting researchers in observing the clinical context to better understand a problem, was used (Mertens, 2009). The data analysis approach is

specifically used in qualitative research analysis and is naturalistic in nature (Hsieh &

Shannon, 2005). A deductive analysis was used to "validate or extend conceptually a

theoretical framework or theory" (Hsieh & Shannon, 2005, p. 1281). Such a direct

approach to qualitative analysis takes into account current theories to both narrow down

the research question and develop an initial set of codes to be used in studies (Hsieh &

Shannon, 2005). In regards to the present study, which aimed to closely examine the use

of therapist self-disclosure during the discussion of trauma, an extensive review of

literature was surveyed and synthesized in order to identify key themes and concepts to

create the initial coding categories. This led to the creation of operational definitions of

therapist self-disclosure and codes that were used in the present study.

The coders involved in the present study also discussed any potential or actual

biases or conflicts of interest that arose during the coding process. Demographic

differences or differences in theoretical orientation may impact the way a particular coder

views instances of therapist self-disclosure, which might then affect the way she codes a

particular item (Ahern, 1999). As such, a reflective journal was utilized to record any

biases or inconsistencies that came up throughout the process, as well as an audit trail of

these results, as recommended by Lincoln and Guba (1985). Researchers met regularly

to discuss and compare their coding, as well as provide these results and discussions to

their auditor for guidance. The auditor then reviewed these potential differences in

coding and engaged in active communication with the coders to ensure reliability of the

findings.

Furthermore, the steps below delineate the specific elements of analysis as

suggested by Stiles et al. (1999) and outlined in the Research Design section of the

present study. Specifically, this study analyzed therapists' [target of measurement] verbal communications [channel of communication] of self-disclosure in single, individual [modality of treatment] psychotherapy sessions [scoring unit] by examining transcriptions [format of data collection] of video recordings and creating nominal coding categories [format of measurement]. This study primarily analyzed the semantic meaning of the therapists' verbalizations [dimension of coding measures]. In order to analyze the qualitative data used in this study based on these coding categories, the researchers used the following steps in adherence with the guidelines outlined by Hsieh and Shannon (2005) for directed content analysis.

Step 1: Highlighting. The researcher participants read through the previously transcribed session transcripts (that included not only verbal information, but also nonverbal behaviors, including gestures, sighs, yawns, body movements, and pauses) and independently highlighted all text that, based on the researchers' first impressions, appeared to indicate verbalizations of therapist self-disclosure (e.g., explicit therapist use of "I" and "we," with "me" being added later in the coding process).

Step 2: Coding selected text. Each researcher then reviewed the highlighted portions of the transcripts and assigned relevant codes where it was deemed applicable (codes are described in detail in the Instrumentation section). These codes were recorded on individual *Microsoft Word* documents; separate documents were created to track notes, questions for the group, coding rationale, and process commentary. All of the text that had been highlighted and appeared to represent therapist verbalizations of self-disclosure based on this study's definition, yet did not fit into any of the predetermined coding categories, were coded with a not otherwise specified/other (NOS/other) code.

The researchers consistently made efforts to identify and analyze any prominent or reoccurring themes that existed within these categories to determine if any additional coding categories or subcategories were warranted to capture such themes (Hsieh & Shannon, 2005); however, no new codes were identified.

At the same time, the researchers remained open to modifying codes throughout the process due to issues and themes that arose. Several modifications were made to the codes based on researcher agreement, including: a) moving verbalizations that included therapy facilitatives (e.g., "Tell me more about that" and "I see"), psychoeducation about therapy (e.g., "That is so common in what we see in PTSD"), and comments about the therapy structure (e.g., "We have a few minutes left") to the NOS/Other category, b) designating SDIS-CON (consistent) or SDIS-INC (inconsistent) only when the client disclosed information first [as it was determined that the therapist's disclosure, in order to be consistent, would need to be reciprocal to the client's and not introduced first], c) adding "me" to the self-disclosure language for which to code (existing language included "I" and "we"), and d) removing ENC (encouraging) and CHA (challenging) codes from the SINV-PERS and SINV-MIST codes since it was deemed too difficult to subjectively fully differentiate these unreliably coded statements due to their complicated and overlapping nature.

Coders 1, 2, and 3 all examined the data independently before meeting as a group to discuss each other's coding choices and reach a consensus. Hill and colleagues (1997) stated that using multiple researchers in this way can be beneficial in that it allows for diverse perspectives and opinions, better captures the complexity of the data, and minimizes individual biases. While meeting to discuss coding decisions, each of the

raters presented her rationale for decisions made. Throughout the discussion portion of coding, when codes were not in 100% agreement, at least one of the coders changed her coding impressions based on input and feedback from the other coders. Typically, this was because one or more of the coders coded a verbalization of self-disclosure as NOS/Other, whether due to individual bias or misunderstanding of the codes. This was particularly noteworthy in the sessions that were coded earlier on, as all three coders were getting acquainted with one another's codes and were more apt to code differently. Through the process of discussing these codes with one another, the team generally reached consensus, which led to increased inter-rater reliability. The purpose of these meetings, however, was not to reach perfect agreement on all coding decisions, but to assist each individual coder in making the decision she deemed most accurate based on more clearly defined codes as described above.

In fact, some codes remained in disagreement following these meetings. For example, in Session 1 the Therapist-Participant stated "Um, yeah, I do feel like getting away… I guess on a vacation" (T45), to which the client replied, "Man, I do too" (C46). Coder 1 initially had coded this example as SDIS-CON-PERS while Coders 2 and 3 coded it as SDIS-CON. After meeting to discuss this code disagreement, it was determined that the Coders would confer with the study auditor before making a final decision regarding this particular code. When it was decided that CON (consistent) would not be coded unless the client disclosed information first, [based on the aforementioned rationale] a final code of SDIS-PERS was agreed upon by all 3 Coders.

When inter-rater disagreement did occur during group discussions, coders documented the rationale for each decision that was made so that the coder judgment

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process was made clear to the auditor (Orwin, 1994). Each coder retained both a copy of his or her initial codes (which were developed independently) as well as the codes that were agreed upon by the group. This process was used to attempt to avoid potential group bias or consensual observer drift in the coding process (i.e., modification of a coder's recorded ratings to be more consistent with another's with whom she had compared; Harris & Lahey, 1982).

During the group discussions, the coders also were encouraged to discuss any potential individual biases that may have influenced their coding so as to be aware of these biases in future coding sessions. While no specific biases were raised by any of the coders, there were times throughout the coding process when misunderstandings occurred. For example, early on in the coding process, one of more of the Researcher-Participants tended to code some verbalizations of therapist self-disclosure as NOS/Other if there was no example of that verbalization included in the coding manual. After a discussion of such coding biases, coders made every attempt to correct them when coding future sessions, as to ensure consistency across sessions.

Inter-rater reliability among the researcher participants was calculated before meeting as a team to discuss initial coding impressions as well as following the discussion of initial codes using Fleiss' Kappa coefficient (K; Fleiss, 1971). These results are summarized in Tables 2 and 3 below. The Fleiss' Kappa coefficient was developed in order to assess whether the agreement reached by raters exceeded that which would be expected by chance (e.g., if coders assigned codes completely randomly; Gwet, 2010). Fleiss' Kappa is appropriate for assessing reliability for a fixed number of raters and nominal-scale ratings, and unlike Cohen's Kappa, this method has the

advantage of being able to assess reliability among more than two raters as is the case in the present study (Fleiss, Cohen, & Everitt, 1969).

Table 2 and Table 3 provide summaries of the K scores, observed agreement, and expected agreement for each individual code as well as averages for the codes across researcher participants. Although no universally agreed upon measure of significance for K values exists, Landis and Koch's (1977) guidelines suggest that $K < 0$ represents poor agreement, $0.01 < K < 0.20$ slight agreement, $0.21 < K < 0.40$ fair agreement, $0.41 < 0.60 < $ moderate agreement, $0.61 < 0.80$ substantial agreement, and $0.81 < K < 1.00$ indicates almost perfect agreement. A negative K value is indicative of a level of agreement that is worse than would be expected completely randomly or by chance.

As can be inferred from Table 2 below, the average Fleiss' Kappa score for codes in this study prior to the team meeting to discuss codes ranged from near perfect agreement (0.925) to moderate agreement (0.499). According to Landis and Koch's (1977) guidelines for interpreting inter-rater reliability, Kappa scores indicate that the team was in agreement near perfectly for SDIS-DEMO and SINV-MIST, in substantial agreement for SDIS-PERS, SDIS-CON-PERS, SINV-PERS, and NOS/Other, and in moderate agreement for SDIS-INC-PERS. Two codes (SDIS-CON-DEMO and SDIS-INC-DEMO) did not receive Fleiss' Kappa scores because they did not appear and were not coded within each of the five transcripts that were selected for the present study (i.e., therapists did not make these types of verbalizations). Table 2 below provides a summary of the average rates of agreement for codes prior to meeting to discuss the codes:

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Table 4

Inter-rater Reliability Coefficients with Three Coders (Pre-Discussion)

	Session 1	Session 2	Session 3	Session 4	Session 5	Average
SDIS-DEMO						
Fleiss' Kappa	1	N/A	N/A	0.661	N/A	0.831
Observed Agreement	1	1	1	0.989	1	0.998
Expected Agreement	0.995	1	1	0.968	1	0.993
SDIS-CON-DEMO						
Fleiss' Kappa	N/A	N/A	N/A	N/A	N/A	N/A
Observed Agreement	1	1	1	1	1	1
Expected Agreement	1	1	1	1	1	1
SDIS-INC-DEMO						
Fleiss' Kappa	N/A	N/A	N/A	N/A	N/A	N/A
Observed Agreement	1	1	1	1	1	1
Expected Agreement	1	1	1	1	1	1
SDIS-PERS						
Fleiss' Kappa	0.855	-.001	N/A	1	N/A	0.618
Observed Agreement	0.995	0.996	1	1	1	0.998
Expected Agreement	0.967	0.996	1	0.989	1	0.990
SDIS-CON-PERS						
Fleiss' Kappa	0.498	N/A	N/A	N/A	1	0.749
Observed Agreement	0.995	1	1	1	1	0.999
Expected Agreement	0.990	1	1	1	.993	0.997
SDIS-INC-PERS						
Fleiss' Kappa	0.499	N/A	N/A	N/A	N/A	0.499
Observed Agreement	0.998	1	1	1	1	>0.999
Expected Agreement	0.997	1	1	1	1	>0.999
SINV-PERS						
Fleiss' Kappa	0.562	0.653	0.846	0.564	0.758	0.677
Observed Agreement	0.981	0.957	0.976	0.909	0.976	0.960
Expected Agreement	0.956	0.878	0.844	0.792	0.899	0.874
SINV-MIST						
Fleiss' Kappa	1	1	N/A	0.774	N/A	0.925
Observed Agreement	1	1	1	0.993	1	0.997
Expected Agreement	0.995	0.979	1	0.968	1	0.988
NOS/Other						
Fleiss' Kappa	0.904	0.698	0.795	0.626	0.580	0.721
Observed Agreement	0.984	0.958	0.976	0.920	0.976	0.963
Expected Agreement	0.835	0.859	0.883	0.787	0.942	0.861

Note: *Table 2* depicts average inter-rater reliability scores for each of the applied codes across sessions using Fleiss' Kappa, Observed Agreement, and Expected Agreement.

N/A is used for Fleiss' Kappa scores for sessions in which the identified code was not applied.

As previously described, after independent coding was completed for each of the transcripts, the researchers met as a group to reach consensus regarding final codes before submitting their findings to the auditor of the study for final review.

Step 3: Submission of codes to auditor. Following the discussions among coders, the codes were then submitted to the auditor for review and approval. In order to make communication between coders and the auditor as clear and detailed as possible, coders submitted an "audit trail," a meticulous description of the research and coding process that clearly outlined the individual and collective coding decisions and thought processes that had taken place. This audit trail is in accordance with research that has shown that the coding process should include decisions about research design, as well as data collection, analysis, and methods of reporting (Halpern, 1983; Lincoln & Guba, 1985).

Each of the researchers also used a technique within the coding process called bracketing, which is commonly used in qualitative research as an attempt to reduce and avoid researcher assumptions from imposing on and shaping the research process (Ahern, 1999). Each researcher therefore provided information pertinent to her own expectations in the electronic transcriptions of selected therapy cases, in addition to individual coding decisions. Specifically, recorded information included: (a) potential assumptions regarding demographic variables such as race, gender, age, and socioeconomic status (e.g., assuming client's race based on language from the transcript prior to learning information regarding demographics of participants); (b) his or her personal values that

are thought to potentially interfere with objectivity; (c) issues regarding potential role

conflict; (d) his or her interests in the data and the extent to which these interests may

dispose him or her to interpret findings favorably (e.g., overinvestment in identifying

self-disclosure codes); and (e) personal feelings that may suggest a lack of neutrality

(e.g., developing a fixed patterns of coding based on positive/negative feelings towards

the client in the transcript; Ahern, 1999). During the coding process, the coders and

auditor shared any information they felt would be pertinent to this discussion with the

group. While none of these potential biases were recorded as coming up throughout the

coding process, all coders considered each of them.

Step 4: Reaching consensus on final codes. Once the codes had been submitted

to the auditor, who checked and provided feedback on the research team's decisions and

judgments up to that point, the coders and auditor discussed the final codes through

ongoing communication on the audit trail. When the auditor provided insight for

continued discussion of codes that led to reconsidering prior coding decisions, the coders

would again discuss any these codes until consensus was reached by the team on the final

codes to be analyzed in the following sections. One example of this occurred during T95

within Session 1, as all three Coders had initially coded the following statement as

NOS/Other:

> Mm-hmm, mm-hmm. [therapist nods head] That, that's kind of uh, umm. How
>
> about, I don't know if you feel comfortable talking about it...but like, how about
>
> sexually, has that impacted you sexually?

However, when this code was reviewed by the auditor, it was pointed out that the

Therapist-Participant was verbalizing her thought/wonder about something the client was

in the process of disclosing in therapy. Upon reflection of the codes and a discussion between the three coders, it was in fact determined that this verbalization would be more appropriate for a SINV-PERS code. Therefore, all three coders agreed to change this code to SINV-PERS as a team. This final discussion process among team members and the auditor continued until all 211 SD codes were reviewed. During this process, several modifications were made to the codes, the changes of which are described in Step 3 above.

Following submission of the codes to the auditor for review, post-discussion rates of agreement on codes were determined. The post-discussion rates of agreement, as summarized in Table 3 below, represent higher values of inter-rater reliability than pre-discussion (see Table 2) because each coder presented a rationale for her coding decision. As such, the following values of Fleiss' Kappa represent a collaborative effort of the coders in order to determine a final coding decision on codes that were previously in disagreement following the independent coding step of the process. As depicted in Table 3, the average Fleiss' Kappa score for each of the 6 codes (SDIS-DEMO, SDIS-PERS, SDIS-CON-PERS, SINV-PERS, SINV-MIST, and NOS/Other) applied in this study following discussion of the codes were in the perfect agreement range (K=1). As discussed previously, three codes (SDIS-CON-DEMO, SDIS-INC-DEMO, and SDIS-INC-PERS) were not applied to and of the five transcripts used in the present study; therefore, no data is available regarding those codes specifically.

Table 5

Inter-rater Reliability Coefficients with Three Coders (Post-Discussion)

	Session 1	Session 2	Session 3	Session 4	Session 5	Average
SDIS-DEMO						
Fleiss' Kappa	1	N/A	N/A	1	N/A	1
Observed Agreement	1	1	1	1	1	1
Expected Agreement	0.995	1	1	0.968	1	0.993
SDIS-CON-DEMO						
Fleiss' Kappa	N/A	N/A	N/A	N/A	N/A	N/A
Observed Agreement	1	1	1	1	1	1
Expected Agreement	1	1	1	1	1	1
SDIS-INC-DEMO						
Fleiss' Kappa	N/A	N/A	N/A	N/A	N/A	N/A
Observed Agreement	1	1	1	1	1	1
Expected Agreement	1	1	1	1	1	1
SDIS-PERS						
Fleiss' Kappa	1	1	N/A	1	N/A	1
Observed Agreement	1	1	1	1	1	1
Expected Agreement	0.958	0.989	1	0.978	1	0.975
SDIS-CON-PERS						
Fleiss' Kappa	1	N/A	N/A	N/A	1	1
Observed Agreement	1	1	1	1	1	1
Expected Agreement	0.995	1	1	1	.993	0.994
SDIS-INC-PERS						
Fleiss' Kappa	N/A	N/A	N/A	N/A	N/A	N/A
Observed Agreement	1	1	1	1	1	1
Expected Agreement	1	1	1	1	1	1
SINV-PERS						
Fleiss' Kappa	1	1	1	1	1	1
Observed Agreement	1	1	1	1	1	1
Expected Agreement	0.879	0.778	0.769	0.692	0.848	0.793
SINV-MIST						
Fleiss' Kappa	1	1	N/A	1	N/A	1
Observed Agreement	1	1	1	1	1	1
Expected Agreement	0.995	0.979	1	0.968	1	0.988
NOS/Other						
Fleiss' Kappa	1	1	1	1	1	1
Observed Agreement	1	1	1	1	1	1
Expected Agreement	0.913	0.959	0.972	0.917	0.974	0.942

Note: *Table 3* depicts average inter-rater reliability scores for each of the applied codes across sessions using Fleiss' Kappa, Observed Agreement, and Expected Agreement.

N/A is used for Fleiss' Kappa scores for sessions in which the identified code was not applied.

Step 5: Evaluation of the coded data. The researcher reviewed the data and tracked the frequency of the different forms of verbal expressions of therapist self-disclosure. This process began with the researcher calculating frequencies for each code within each session and tracking these frequencies using Microsoft Excel spreadsheets. She then further examined the data for any patterns (e.g., types of self-disclosure used vs. trauma vs. non-trauma discussion, analysis of codes within the SINV-PERS and NOS/Other categories) that existed within the sessions as well as shed light on cultural variables that may have contributed to the findings (e.g., type of trauma, degree of self-disclosure) in sessions that involved trauma discussions.

Step 6: Presentation of findings. Lastly, findings from this study are presented in the following two chapters with regards to the frequencies of the coded verbalizations of therapist self-disclosure data and the context in which they were assigned. The frequencies of the specific types of therapist self-disclosure elucidated how often the therapist participants used different forms of self-disclosure within the context of therapy sessions that included discussions of trauma. Furthermore, analysis of therapist self-disclosure during trauma discussions versus non-trauma discussions and other themes (i.e., when disclosures occurred in the session, codes present within the NOS/Other category) are included for further interpretation and understanding. The chapters below present sample quotations to provide a richer understanding of the manner in which student therapists' used self-disclosure with clients who have experienced trauma.

Chapter III. Results

This chapter reviews results obtained from the qualitative content analysis of student therapists' expressions of self-disclosure with clients who have experienced trauma. The specific purpose of this analysis was to examine the various ways in which student therapists verbalize different forms of self-disclosure with clients who have experienced trauma. To obtain a comprehensive representation of the data, codes were first analyzed in relation to the full psychotherapy session, and then coded sections of the transcript that were identified as the trauma discussion were differentiated from and compared with sections identified as the non-trauma discussion.

The coding system that was utilized for the analysis of therapist self-disclosure across five sessions (T1; 7th session of 21, T3; 6th session of 31, T4; 1st session of 3, and two were unknown (T2 and T5)) with five different therapists-client dyads was based on an in-depth review of the extant literature on therapist self-disclosure both generally and with clients who have experienced trauma (see Appendix A for detailed information on coding system). The codes used in the current study were: (a) Demographic Self-Disclosures (SDIS-DEMO, SDIS-CON-DEMO, SDIS-INC-DEMO); (b) Personal Self-Disclosures (SDIS-PERS, SDIS-CON-PERS, SDIS-INC-PERS); (c) Self-Involving Disclosures (SINV-PERS, SINV-MIST); and (d) Self-Disclosures that are Not Otherwise Specified (NOS/Other). Of note, three of these codes (SDIS-CON-DEMO, SDIS-INC-DEMO, and SDIS-INC-PERS) are not reported in the results that follow because none of the transcripts included therapist verbalizations that fell into these categories.

The following sections provide a review of the directed content analysis findings across and within psychotherapy sessions. Findings across sessions begin with a

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discussion of overall code frequencies, then more specifically within and across Trauma

Discussions and Non-Trauma Discussions. Subsequently, a content analysis across

sessions/participants is presented that combines coding frequencies as well as examples

of coded therapist self-disclosure verbalizations using quotations obtained from the

various transcribed psychotherapy sessions used for this study. The results section ends

with a presentation of the within session coding frequencies and additionally provides

qualitative examples of therapist verbalizations of self-disclosure from within each

specific session.

Overall Code Frequency Across Sessions

The content analysis of verbalizations of student therapist self-disclosure by

trauma survivors in individual psychotherapy sessions yielded 211 codes among the

1,369 talk turns. The amount of client talk turns that occurred during each session ranged

from 184 to 418, with a mean of 273.8 client talk turns per session (*SD*=95.86).

Furthermore, student therapist verbalizations of self-disclosure took place in 15.41% of

talk turns from all five transcribed psychotherapy sessions. Across the five psychotherapy

sessions, the total number of therapist self-disclosure codes ranged from 30 (session five)

to 58 (session one), with a mean average of 42.2 codes (*SD*=12.28) over all five sessions.

These 211 overall codes, agreed upon by the researcher participants (coders), were

applied from four broad categories of therapist self-disclosure: (a) Demographic Self-

Disclosures (SDIS-DEMO; *n*=4, 1.90%); (b) Personal Self-Disclosures (SDIS-PERS;

n=12, 5.69%; SDIS-CON-PERS; *n*=2, 0.95%); (c) Self-Involving Disclosures (SINV-

PERS; *n*=148, 70.14%; SINV-MIST; *n*=6, 2.84%); and (d) Self-Disclosures that are Not

Otherwise Specified (NOS/Other; *n*=39, 18.48%). Table 4 below provides an overall

summary of the percentages of self-disclosure (SD) codes identified in each of the five

psychotherapy sessions in this study. It should be noted that these codes are presented in

order of frequency primarily for the purpose of organization, rather than to suggest that

any of the codes are more significant than others.

Table 6

Overall Coding, Talk Turn Frequencies and Percentages Across Sessions

	Session 1	Session2	Session3	Session4	Session 5	Total
Total Codes	58	31	41	51	30	211
Total # Talk Turns	418	189	278	184	300	1,369
% of SD	13.88%	16.40%	14.75%	27.72%	10.00%	15.19%

The individual codes are presented in order of frequency in Table 5 below, which

provides a graphic depiction of coding frequencies within and across sessions. The figure

below depicts only those coding categories from which individual codes were applied

during the coding process (i.e., SDIS-DEMO, SDIS-PERS, SDIS-CON-PERS, SINV-

PERS, SINV-MIST, and NOS/Other).

Table 7

Overall Individual Code Frequencies Across Sessions

	Session 1	Session 2	Session 3	Session 4	Session 5	Total
SDIS-DEMO	1	0	0	3	0	4
SDIS-PERS	9	1	0	2	0	12
SDIS-CON-PERS	1	0	0	0	1	2
SINV-PERS	27	24	37	35	25	148
SINV-MIST	1	2	0	3	0	6
NOS/Other	19	4	4	8	4	39
TOTAL	58	31	41	51	30	211

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

Next, analyses were conducted to differentiate between verbalizations of therapist self-disclosure that occurred during discussions of trauma versus non-trauma discussions. After reporting separate data for trauma discussions and non-trauma discussions, comparative data will be shared.

There were 701 talk turns across five sessions that met criteria for trauma discussion. During trauma discussions (TD), 4 of the 6 overall codes used in this study were applied to therapist verbalizations of self-disclosure (SDIS-PERS, SINV-PERS, SINV-MIST, NOS/Other) while 2 were not coded during trauma discussions (SDIS-DEMO and SDIS-CON-DEMO). Across the trauma discussions within each session, the total number of therapist self-disclosure codes ranged from 11 (Session 1) to 27 (Session 3), with a mean average of 19.6 codes (SD=7.13) over all five sessions. A total of 98 TD codes were applied from the following three broad categories: (a) Personal Self-Disclosures (SDIS-PERS; n=1, 1.02%); (b) Self-Involving Disclosures (SINV-PERS; n=78, 79.59%; SINV-MIST; n=1, 1.02%); and (c) Self-Disclosures that are Not Otherwise Specified (NOS/Other; n=18, 18.37%).

There were 668 talk turns across all five sessions that met criteria for non-trauma discussion. During non-trauma discussions (NTD), all 6 codes were applied to therapist verbalizations of self-disclosure. Across the NTD within each session, the total number of therapist self-disclosure codes ranged from 8 (Session 2) to 47 (Session 1), with a mean average of 22.6 codes (SD=15.27) over all five sessions. These 113 total NTD codes were applied from the following four broad categories: (a) Demographic Self-Disclosures

(DSIS-DEMO; *n*=4, 3.54%); (b) Personal Self-Disclosures (SDIS-PERS; *n*=11, 9.73%;

SDIS-CON-PERS; *n*=2, 1.77%); (c) Self-Involving Disclosures (SINV-PERS; *n*=70,

61.95%; SINV-MIST; *n*=5, 4.42%); and (d) Self-Disclosures that are Not Otherwise

Specified (NOS/Other; *n*=21, 18.58%).

Comparisons between TD and NTD data are presented next. In Table 6, therapist

self-disclosure frequency and percentage analyses are differentiated within the trauma

discussion and non-trauma discussion for comparison.

Table 8

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

	Session 1	Session2	Session3	Session 4	Session 5	Total
Total Codes TD	11	23	27	24	13	98
Total Codes NTD	47	8	14	27	17	113
Talk Turns TD	(109)	(159)	(178)	(113)	(142)	(701)
Talk Turns NTD	(309)	(30)	(100)	(71)	(158)	(668)
Talk Turns Overall	(418)	(189)	(278)	(184)	(300)	(1,369)
% of SD TD/Overall	(10.09%)/ (2.63%)	(14.47%)/ (12.17%)	(15.17%)/ (9.71%)	(21.24%)/ (13.04%)	(9.15%)/ (4.33%)	(13.98%)/ (7.16%)
% of SD NTD/Overall	(15.21%)/ (11.24%)	(26.67%)/ (4.23%)	(14.00%)/ (5.04%)	(38.03%)/ (14.67%)	(10.76%)/ (5.67%)	(16.92%)/ (8.25%)

The individual codes that were assigned during TD and NTD are presented in

order of frequency in Table 7 below, which provides a graphic depiction of coding

frequencies within and across sessions. In regards to Table 7, all six of the codes are

included in order to provide a basis for comparison to the overall results described earlier

and as a means of comparing them to each other. However, the three codes that were not

used during the coding process (SDIS-CON-DEMO, SDIS-INC-DEMO, and SINV-INC-

PERS) are not included in Table 7.

Table 9

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

	Session 1	Session 2	Session 3	Session 4	Session 5	Total
SDIS-DEMO (TD)	0	0	0	0	0	0
SDIS-DEMO (NTD)	1	0	0	3	0	4
SDIS-PERS (TD)	0	0	0	1	0	1
SDIS-PERS (NTD)	9	1	0	1	0	11
SDIS-CON-PERS (TD)	0	0	0	0	0	0
SDIS-CON-PERS (NTD)	1	0	0	0	1	2
SINV-PERS (TD)	5	18	25	18	12	78
SINV-PERS (NTD)	22	6	12	17	13	70
SINV-MIST (TD)	0	1	0	0	0	1
SINV-MIST (NTD)	1	1	0	3	0	5
NOS/Other (TD)	6	4	2	5	1	18
NOS/Other (NTD)	13	0	2	3	3	21
TOTAL (TD)	11	23	27	24	13	98
TOTAL (NTD)	47	8	14	27	17	113

Content Analysis: Synthesizing Coded Results Across Sessions/Participants

The following section provides a synthesis of therapist self-disclosure code results across all five individual psychotherapy sessions. In other words, when reviewing and comparing the frequency and percentages results obtained from fully coded sessions with trauma (TD) versus non-trauma discussions (NTD) across participants, qualitative examples of therapist self-disclosure within each of the coding categories are also provided. These results are reported next in the order of coded frequency

Self-Involving statements. Across all five psychotherapy sessions, therapist-participant verbalizations of self-involving disclosures (SINV-PERS; those that involved personal feelings, thoughts, and reactions that arise in and about the therapy and the therapy process) were most frequently coded, and overall represented 70.14% of therapist self-disclosure codes (*n*=148). When further differentiated by TD versus NTD, analyses revealed that therapists were more likely to use self-involving disclosures during discussions of trauma (*n*=78, 79.59% of TD codes) than during non-discussions of trauma (*n*=70, 61.95% of NTD codes), when calculated in context with the respective number of talk turns in each section.

Therapist verbalizations that received SINV-PERS codes were quite diverse in their nature, but all referred to what was going on inside the therapy room at that given moment. For example, in Session 3, the therapist made the following statement immediately upon walking into session, "We are right there today. We don't have to be in the kids room [T laughs] Let's find us a real one this time." Another example came Session 4, as the therapist explained to the client the procedures involved in an intake, when she stated,

I know, I know we'll try to get through whatever we can today and finish up next

time. You know they as they said of the phone today is twenty five dollars for the

intake generally and then we'll talk about the fee on sliding scale (T11)

Lastly, in Session 1, the therapist repeatedly used the SINV-PERS coded phrase, "You

know what I mean?" when talking to the client and also at one point stated, "Should we

move on?" (T313), in regards to their conversation.

Also included in this self-involving category were therapist disclosures that

include admission of mistakes (SINV-MIST). Across the five psychotherapy sessions,

therapist self-disclosures of mistakes overall accounted for 2.84% of all coded disclosures

(n=6; out of 211). Additionally, therapist admission of mistakes tended to occur more

frequently within non-trauma discussions (n=5, 4.42% of TD) than within trauma

discussions (n=1, 1.02% of NTD). An example of SINV-MIST occurred in Session 4 as

the therapist and client entered the therapy room, to which the therapist stated, "Alright,

I'm really sorry, but that, that we're right in this room." At the very end of Session 1, the

therapist stated, "Just put session 7. I should have it done every 5 sessions but it's ok." In

both of these examples, it was clear to the coders that the therapist was either apologizing

or admitting to making a mistake within the context of therapy. Of note, the therapist

admission of a mistake that occurred within the trauma discussion in Session 2 when the

therapist stated, "Okay and I am sorry I didn't return your phone call, I just got your

message." All verbalizations that were coded SINV-MIST involved verbalizations that

fell into either the apology or admission of mistake categories.

Not otherwise specified/other disclosures. After disclosures of a self-involving

personal nature, the next highest frequency of codes that were assigned in the present

study fell under the NOS/Other category of codes (*n*=39) and accounted for 18.48% of all codes. Additionally, these codes appeared equally in both trauma discussions (*n*=18, 18.37%) as well as in non-trauma discussions (*n*=21, 18.58%).

Within the NOS/Other category, four main categories or themes of therapist self-disclosure were identified, which included: a) psychoeducation, b) comments related to session structure, c) non-specific or incomplete statements, and d) therapy facilitatives. Some examples of verbalizations that were coded as NOS/Other included psychoeducation about what the therapist gained through experience in the mental health field, such as the following:

> I think a lot of times, especially when children go through a traumatic thing in their lives and for you it was very, something that was very, completely traumatic but even something that, you know, for a child can be traumatic that might not seem traumatic to an adult, that can, it kind of creates an issue where children need control over certain things, and it goes into adulthood, so maybe not having, maybe someone… (T167, Session 5)

Additionally, statements referring to session structure ("I think we're out of time"), therapy facilitatives ("Tell me about that"), and incomplete thoughts ("I mean…") were coded within this category.

Self-Disclosing statements. Across all five psychotherapy sessions, therapist verbalizations of self-disclosing statements (SDIS-DEMO, SDIS-PERS, SDIS-CON-PERS) accounted for 8.53% of all codes (*n*=18). More specifically, SDIS-PERS codes made up 5.69% of all codes (*n*=12), SDIS-DEMO codes made up 1.90% of all codes (*n*=2), and SDIS-CON-PERS codes made up 1.90% of all codes (*n*=2).   With further

analysis, it was determined that verbalizations of self-disclosing statements, or statements that revealed demographic or personal information about the therapist, tended to occur most frequently during non-trauma discussions (*n*=17, 15.04%) rather than during trauma discussions (*n*=1, 1.02%). The one personal self-disclosing statement (SDIS-PERS) that occurred during the non-trauma discussion during Session 4 involved the therapist stating, "Yes we are a Christian university, but I don't approach psychology through a Christian lens" (T104). Of note, this personal disclosure occurred in the middle of the session, between identified trauma discussions (T25-T95 and T106-T143).

Examples of therapist verbalizations of self-disclosing statements included, "I guess I would umm, start umm I'd call up my boyfriend and tell him I love him" in response to a game question and "That's where I was coming from too" in Session 1. During the trauma discussion in Session 4, the therapist stated to the client, "If we you mentioned you wanted to work on some relaxation techniques we'll definitely do that and it's an area my background expertise in research," thereby revealing personal information about herself and her background in psychology.

Content Analysis: Synthesizing Coded Results Within Participants

This section also presents code frequencies as well as qualitative descriptions of codes (e.g., examples of specific statements that characterized different verbal expressions of therapist self-disclosure), but here does so for each transcribed session. Each session that was transcribed and coded included a discussion of trauma; the entire transcribed session, as well as solely the portion comprising the discussion of trauma, was coded for therapist expressions of self-disclosure. The findings are discussed in order of prevalence within this section.

Session 1. Session 1 involved a female Therapist-Participant and an African American, Christian female Client-Participant that took place when the client was 28 years old. The coders and previous dissertation lab teams experienced her presentation as that of an expressive, playful, and resilient woman. The client sought therapy to deal with adjustment issues related to relocating to a new city and difficulties with expressing and coping with her emotions. She also reported a trauma history marked by her uncle raping her when she was in the 3rd grade. During this session, which was listed as session 7 on the transcript, the therapist and client engaged in a therapeutic "feeling game" that consisted of each of them taking turns answering questions and prompts from the game cards they selected.

During the feelings game, when one of the cards the client-participant selected asked her to "talk about something you will never forget," she discussed the sexual trauma she experienced as a child, which began in the 46th talk turn. During this trauma discussion, which overall comprised 109 talk turns (T46-T120, T155-T157, T210-T244), the client talked about the details of the abuse and how the experience shaped her beliefs and impacted her current romantic and interpersonal relationships. The second discussion of trauma began at T155, when the therapist was prompted by the game to "say something about child abuse." The therapist then discussed with the client how it is "never the victim's fault, and it's always the perpetrator's fault." Lastly, the third and final discussion of trauma began at T210, during which the therapist discussed with the client how even if the victim of child abuse enjoyed it or "wants it", he/she is not old enough to consent to sexual behavior and that because of this lack of maturity and development, the abuse is always the perpetrator's fault.

Of the 418 talk turns that comprised Session 1, verbalizations of therapist self-disclosure were coded 58 times, which accounted for 13.88% of the overall session. More specifically, self-disclosure was coded within all four broad coding categories in the first session and all 6 codes were applied: (a) Self-Involving Disclosures (SINV-PERS; n=27, 46.55%; SINV-MIST; n=1, 1.72%), (b) Personal Self-Disclosures (SDIS-PERS; n=9, 15.52%; SDIS-CON-PERS; n=1, 1.72%), (c) Demographic Self-Disclosures (SDIS-DEMO; n=1, 1.72%), and (d) Self-Disclosures that are Not Otherwise Specified (NOS/Other; n=19, 32.76%).

Analyses indicate that within Session 1, self-disclosures took place more often in non-trauma discussions (NTD; n=47, 81.03%) than during trauma discussions (TD, n=11, 18.97%). Of all five sessions, Session 1 contained far more coded verbalizations of therapist self-disclosure within the NTD than in the TD, an occurrence that only occurred in one other session, with that much lower contrast having occurred during Session 5 (NTD=17, TD=13). During NTD, all 6 codes were applied to 47 therapist verbalizations of self-disclosure within Session 1, and accounted for the following breakdowns in coding categories: (a) Self-Involving Disclosures (SINV-PERS; n=22, 46.81%; SINV-MIST; n=1, 2.13%), (b) Personal Self-Disclosures (SDIS-PERS; n=9, 19.15%; SDIS-CON-PERS; n=1, 2.13%), (c) Demographic Self-Disclosures (SDIS-DEMO; n=1, 2.13%), and (d) Self-Disclosures that are Not Otherwise Specified (NOS/Other; n=13, 27.66%). Within the three identified trauma discussions that took place in Session 1, only two codes (SINV-PERS and NOS/Other) were applied 11 times to therapist verbalizations of self-disclosure within the TD. Personal self-involving disclosures

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accounted for 45.45% of the TD portions of this transcript (n=5) and Self-Disclosures that are Not Otherwise Specified accounted for 54.55% of TD codes (n=6).

Self-Involving disclosures. As noted above, the therapist and client were playing a game; the therapist consistently used self-disclosure language ("I" and "we") when referring to the game, which contributed to a higher overall number of Personal Self-Disclosure (SINV-PERS) codes. Of note, in Session 1, there were substantially more SINV-PERS disclosures that occurred during the NTD (n=22) than during the TD (n=5). In the other sessions, there tended to be opposite patterns that emerged (TD>NTD and TD=NTD). Of the 22 disclosures that occurred during NTD, 11 of those included verbalizations that referred to the game. For example, the therapist made comments such as, "I thought maybe we could play," (T8) "We can decide how much we want to like play," (T16) and "I can't really comment on it unless I land on the comment section," (T21) in reference to what was occurring within the therapy session. In fact, the therapist also used self-disclosure in response to the game prompts. For example, after picking a card that prompted her to share a discovery she had made in her life recently she stated, "I'm always talking [therapist mumbles something] talking. Umm, I guess, something in my life, uh, I have learned that, um, whatever that, from my classes I guess" (T31) and then goes on to say "[What] happened in the past does have an effect on me later" (T32). The therapist then continued to use self-disclosure language when explaining the rules of the game by stating, "Yeah, I think, um, I think the Might Mountain is, here" (T36) and "That's the sailboat and I guess I can go over here" (T44). In regards to the SDIS-MIST code (as noted above), it occurred when the therapist stated, "Just put session 7. I should have it done every 5 sessions but it's ok" (T417).

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There were 5 therapist verbalizations of self-disclosure that occurred within the TD also. For example, during the initial trauma discussion related to the client's sexual assault as a child, examples of SINV-PERS therapist statements included, "You told me about your uncle, yeah" (T57) and introduced a question she had about the client's current relationships with the phrase "I'm just wondering…" (T76).

Personal self-disclosures. Within Session 1, the therapist made 10 personal self-disclosures (SDIS-PERS), and all in non-TD. Generally, the therapist made statements like, "Yeah, I won't get in trouble" (T418) in response to not having given the client the paperwork in the time frame she was supposed to, and "I've never tried to buy one" (T9) when referring to the therapeutic game. Only one personal self-disclosure was consistent with the client's experience (SDIS-CON-PERS), and overall only 2 of the 5 therapists made such a comment in any of the five sessions. After the client gave an answer to one of the game questions, the therapist stated, "I wish I had that answer" (T348), which was consistent with the disclosure that the client had just previously made.

Demographic self-disclosures. As stated in a previous example, the therapist made one demographic self-disclosure (SDIS-DEMO) during the course of the session, which occurred in the NTD. Demographic self-disclosures were only found in one other session (T4, n=3). When asked by the game what she would do if she found out she was going to die soon, the therapist responded by saying, "Oh my goodness. I guess I would umm, start umm I'd call up my boyfriend and tell him I love him" (T336).

Self-Disclosures not otherwise specified. Throughout Session 1, the Therapist-Participant made 19 NOS/Other disclosures, which accounted for 32.76% of disclosures. Of the five sessions, this represented the highest amount of coded NOS/Other disclosures,

with the next lowest being 8 codes (T4) and the other three sessions containing 4 each. More specifically, therapist disclosures fell into the following categories: a) Incomplete/non-specific verbalizations (n=11, 57.89%; "I thought, well, do you have something to…no?" (T5); "Like, I'm just wondering, did you become, I mean" (T76); "You felt anger, I guess, you know" (T300)), b) Psychoeducation (n=1, 5.26%; "I'll say something. The victim's, it's never the victim's fault" (T155)), c) Therapy facilitatives (n=6, 31.58%; "You know what I mean?"(T167)), and d) Session structure (n=1, 5.26%; "Um, let's kind of wrap this up" (T402)).

In addition to this particular session having the highest frequency of NOS/Other codes, it was unique in that more of these disclosures took place during the NTD (n=13) than in the TD (n=6), a finding that occurred in only one other session but at a lower frequency (Session 5; NTD=3, TD=1). Within the NTD, the Therapist-Participant stated, "I thought that maybe, um, this is a game" (T7) and "Oh yeah, it's kind of like that I guess" (T13). Some examples of NOS/Other codes within this transcript that occurred within the TD included the therapist starting with, "I'll say something. The victim's, it's never the victim's fault" (T155) in response to a card prompting her to say something about child abuse, and "We're generally happier usually I think, when things are more controlled in our environment" (T173).

Session 2. Session 2 involved a female Therapist-Participant and a 47-year-old single, Caucasian female Client-Participant, who reported that she was originally from England. She reported being unemployed at the time of her session due to her disability status. Client-Participant 2 identified the loss of her eyesight as a trigger for other problematic behaviors, such as compulsive scratching, and needing to depend on others,

the impetus for seeking therapy. One year prior to starting therapy she suffered a stroke that caused her to lose her eyesight.

Because a majority of the 189 total talk turns in the session were spent discussing the client's medical trauma, the trauma discussion was deemed to start at C7 and end at C166 (for a total of TD 159 talk turns). During this trauma discussion, the client expressed her apprehension regarding her upcoming surgery to be performed on her eye. The client talked about the details of her stroke and the numerous hospital visits and surgeries she had endured. She discussed multiple health issues that occurred as a result of her stroke and described the social support she has received from others as well as her caretakers throughout this process. Additionally, the therapist explored the connection between the client's scratching behavior and her stress level. Non-trauma discussion (NTD) portions of Session 2 included the very beginning of session (C1-T6) when the therapist and client discussed the weather, and the end of session (T166-T189) as they discussed the logistics of scheduling sessions and payment options for the client.

Of the 189 total talk turns that comprised Session 2, verbalizations of therapist self-disclosure were coded 31 times, which accounted for 16.40% of the overall session. More specifically, self-disclosure was coded within three broad coding categories in the second session and 4 codes were applied: (a) Self-Involving Disclosures (SINV-PERS; n=24, 77.42%; SINV-MIST; n=2, 6.45%), (b) Personal Self-Disclosures (SDIS-PERS; n=1, 3.23%), and (c) Self-Disclosures that are Not Otherwise Specified (NOS/Other; n=4, 12.90%).

Analyses indicate that within this transcript, self-disclosures took place more often in trauma discussions (TD, n=23, 74.19%) than during non-trauma discussions

(NTD, n=8, 34.78%), which occurred in only one other session (T3; TD=27, NTD=14).

This might be explained by the fact that most of the session (159 out of 189 talk turns,

84.13%) was deemed to be inclusive of a trauma discussion, which is a higher percentage

of overall TD in relation to the overall session than any of the other four sessions

included in this study. Within the identified trauma discussion (C7-C166) that took place

in Session 2, three codes were applied to therapist verbalizations of self-disclosure

(SINV-PERS, NOS/Other, and SINV-MIST) for a total of 23 codes within the TD.

Personal self-involving disclosures accounted for 82.61% of the TD portions of this

transcript (SINV-PERS, n=18; SINV-MIST, n=1) and Self-Disclosures that are Not

Otherwise Specified accounted for 17.39% of TD codes (NOS/Other, n =4).

During NTD, 3 codes were applied to 8 therapist verbalizations of self-disclosure

within Session 2, and accounted for the following breakdowns in coding categories: (a)

Self-Involving Disclosures (SINV-PERS; n =6, 75.00%; SINV-MIST; n =1, 12.50%) and

(b) Personal Self-Disclosures (SDIS-PERS; n =1, 12.50%). This finding represented the

lowest number of NTD codes that were applied within any given session, with the next

highest number of NTD codes occurring in Session 4 (n =14).

Self-Involving disclosures. Within Session 2, self-involving disclosures (SINV-

PERS) occurred most frequently, making up more than 77% of all 31 therapist-

participant disclosures, which is a similar amount to the other four sessions. Near the

start of session, as the client discussed her concerns about her upcoming surgery, the

therapist stated to the client, "I can understand your fears and concerns" (T32) and "It

sounds very scary to me" (T81). Later, the therapist went on to give the client some

advice on what she could do to help herself cope with stress by saying:

I think just getting out… And to keep your hands busy and to let go of some of

those upsetting feelings [client nodding] because, um, you are going to have a lot

of frustrating experiences going through what you are going through and maybe

one technique, and I don't know if it will work or not, but writing down what

you're feeling. (T54-55)

Then, she continued to use self-involving disclosure when she said, "We can see how it

works" (T63), referring to the client following through on her advice. Lastly, an example

of a code for SINV-PERS in this session occurred when the therapist brought the client

back to a previous point in time by stating, "It reminds me of when you said, in your

childhood, you felt clumsy" (T98). The majority of SINV-PERS statements were coded

within the TD (n =18), while less occurred within the NTD (n =6).

Additionally, there were two times in Session 2 when the coders deemed that the

therapist disclosed an admission of a mistake made on her part. These two examples

included, "Okay and I am sorry I didn't return your phone call, I just got your message"

(T161, in TD) and "I was supposed to give it to you at the end of last session" (T182, in

NTD), both of which occurred toward the end portion of the session. Of note, Session 2

was the only session during which a SINV-MIST code was applied during a TD (see

T161 example). Also, it was one of two sessions during which a SINV-MIST code was

applied at all; the other was Session 4 (SINV-MIST; n =3, all NTD).

Personal self-disclosures. Only one therapist self-disclosure of a personal nature

was coded within this session. This non-TD code occurred when at the end of the

session, the therapist told the client, "Those are better days for me so leave a time, or a

couple of times, and then I'll get back to you" (T174), referring to her own schedule.

Self-Disclosures not otherwise specified. There were 4 therapist verbalizations of self-disclosure that were determined to fall into the NOS/Other category, which was the same total number of NOS/Other codes that occurred in two other sessions (T3 and T5). All 4 verbalizations occurred within the TD during this session. Of these 4 disclosures, 3 were determined to be therapy facilitatives (75.00%) while 1 was determined to be an incomplete thought (25.00%). T22, T30, and T111 included therapy facilitatives when the therapist stated, "So, um, I understand that you said you feel worried about the outcome?" "I see," and "I thought that…" Additionally, she verbalized an incomplete thought when she said, "All I can think of is, is that, you are going to have a big life change either way" (T89).

Session 3. Session 3 involved a female Therapist-Participant and a 21-year-old married, Hispanic Christian female Client-Participant. Client-Participant 3's highest level of education was high school, and she immigrated to the United States from El Salvador when she was 19 years old. The client reported a history of physical, sexual, and emotional childhood abuse, including physical abuse by mother and grandmother (e.g., her mother used a knife to threaten her numerous times), and two instances of sexual abuse (perpetrators and age unknown). She was referred to therapy by her husband to address feelings of hopelessness, guilt, anger, depression, and suicidal ideation. Current and previous PARC researchers agreed that her presence in the session was typically serious and tearful and the client spoke with an accent as English was her second language. During this session, which was listed as the client's 6th therapy session, the client discussed how she is concerned for the safety of her sisters who were residing with her parents and grandmother in El Salvador.

Of the 278 total talk turns that comprised Session3, verbalizations of therapist

self-disclosure were coded 41 times, which accounted for 14.75% of the overall session.

More specifically, self-disclosure was only coded within two broad coding categories: (a)

Self-Involving Disclosures (SINV-PERS; n =37, 90.24%) and (b) Self-Disclosures that

are Not Otherwise Specified (NOS/Other; n =4, 9.76%). There were no instances of

therapist disclosures in this session that were coded within the broader Demographic

Self-Disclosure or Personal Self-Disclosure categories of codes, which is unique to

Session 3. Over half (178 of the 278) of the total talk turns that took place in this session

(C91-T269), were determined to be inclusive of a discussion of trauma based on the

information that was included in the transcript. The majority of the session addressed the

client's familial relationships and her memories of the past abuse she experienced.

Analyses indicated that within Session 3, self-disclosures took place more often in

trauma discussions (TD, n =27, 65.85%) than during non-trauma discussions (NTD, n

=14, 34.15%), which only occurred in one other session (T2; TD=23, NTD=8). Of all

five sessions, Session 3 had the highest frequency of codes that occurred during the TD

(n =27), with the next lowest number of codes occurring within Session 4 (n =24).

Within the identified trauma discussion (C91-T269) that took place in Session 3, 2 codes

were applied to therapist verbalizations of self-disclosure (SINV-PERS and NOS/Other)

for a total of 27 codes within the TD. Personal self-involving disclosures accounted for

92.59% of the TD portions of this transcript (SINV-PERS, n =25) and Self-Disclosures

that are Not Otherwise Specified accounted for 7.41% of TD codes (NOS/Other, n =2).

Self-Involving disclosures. Within Session 3, Self-Involving Disclosures (SINV-

PERS) made up 90.24% of all verbalizations of self-disclosure that were coded. This was

the highest number (*n* =25) of SINV-PERS (with the next lowest amount coded in Sessions 2 and 4, *n* =18) codes that were coded across all five sessions and also represents that highest percentage of SINV-PERS codes to overall session across all five sessions.

Of the TD-inclusive SINV-PERS disclosures that occurred within Session 3, many included therapist verbalizations that focused on what was going on between the therapist and client in the room. For example, the therapist stated things like, "I remember you saying that" (T85), "I noticed you said that," (T130) and "we'll talk about that one, too" (T63). Additionally, there were times that the therapist disclosed her knowledge and opinion to the client, like when she stated, "I know they live near your, I know they live near each other" (T106-107) and "I'm glad to see that you don't have any thoughts about hurting yourself or killing yourself" (T91), respectively. Some other examples of therapist self-disclosure that occurred within the TD include, "You feel so upset, I know" (T149), "I think that's what I mean," (T164), "I mean I noticed you said the whole family is crazy…" (T167), and "I need to, I'm tell you that you're saying something very important (T181)."

During the NTD portions of session 3, therapist self-disclosure was coded a similar number of times (*n* =12) when compared with the other sessions. In this session, the therapist began the session by stating, "We are right there today. We don't have to be in the kids' room. Let's find us a real one this time" (T1). She then went on to use self-disclosure in discussing the client's fee for therapy and in filling out an assessment measure with the client, which account for the self-disclosures that occurred at the beginning of session:

I just, you know, first, I know I mentioned to you, um, before on the phone but,

um, I wanted to talk about the fee. I want to make sure that you feel that you can

pay it. And so I talked to my supervisor - this is stuck on the - I talked to my

supervisor and we want to make sure, we want you to come in, you know what I

mean. We don't want you, we want you to pay what you feel you can pay (T4)

and

Today is the twentieth I think actually. Great. And then the other thing I just have

really quickly, was just I want to check in cause I haven't seen you in two weeks,

so I just wanted to kinda check in on how you're feeling. We filled this out

together before, right, about how you're feeling, like if you're feeling sad. Would

that be okay, if we filled that out? (T19)

Self-Disclosures not otherwise specified. There were 4 therapist verbalizations of

self-disclosure that were coded within the NOS/Other category (9.76%) in Session 3, an

amount that is consistent with other sessions. NOS/Other coded were applied equally

within TD (n =2) and NTD (n =2) portions of this session. More specifically, 3 of these

disclosures were coded as incomplete thoughts (75.00%; "Today is the twentieth I think

actually" (T19, NTD); "So, I'm going to say…" (T21, NTD); I mean does that, do you

think that, is that a possibility right now…" (T217, TD)), while 1 was coded as a therapy

facilitative (25.00%; "Um, why don't you tell me a little bit about what's going on" (T99,

TD)).

During NTD, 2 codes were applied to 14 therapist verbalizations of self-

disclosure within Session 3 (SINV-PERS; n =12, 85.71% and NOS/Other; n =2, 14.29%).

In addition to the beginning of session disclosures that involved setting a fee and going

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over an assessment measure that were discussed earlier, the therapist returns to this fee topic at the end of session after the TD had ended. She said,

> But I'll find out, I'm not sure if we can maybe give you money back on that or I don't really know how that quite works. You know I'm sure he's going to, you know we talked about it already so maybe next time it's like, well what easier for you? Do you think you can maybe pay twenty-five or thirty? I want you to be honest (T272; SINV-PERS)

Session 4. Session 4 involved a female Therapist-Participant and a 39-year-old married, multi-racial (African American, American Indian, and Caucasian) female Client-Participant. The client reported that she had four daughters, two of whom had moved away from home to attend college. At the time of Session 4 (which was an intake session), she was living at home with her husband and two daughters, one of which was her stepdaughter. Self-referred to therapy, she wanted to better manage her emotions of depression, guilt and anger that arose after discovering that her father sexually abused her stepdaughter. The client reported a history of being sexually abused by her paternal grandfather when she herself was 6-7 years old. The intake session that was transcribed focused on gathering information about the clients presenting problems and background. Of the 184 total talk turns that made up session 4, 113 were deemed to meet criteria for TD, which occurred in three separate parts of the transcript (T25-T95, T106-T143, and T150-T156). These TDs focused on the client's sexual abuse as well as the sexual abuse of her stepdaughter.

Of the overall total talk turns that comprised Session 4, verbalizations of therapist self-disclosure were coded 51 times, which accounted for 27.72% of the overall session

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and represented the second highest number of overall codes across sessions. More specifically, self-disclosure was coded within the four broad coding categories in the fourth session and 4 codes were applied: (a) Self-Involving Disclosures (SINV-PERS; n =35, 68.63%; SINV-MIST; n =3, 5.88%), (b) Demographic Self-Disclosures (SDIS-DEMO; n =3, 5.88%), (c) Personal Self-Disclosures (SDIS-PERS; n =2, 3.92%), and (c) Self-Disclosures that are Not Otherwise Specified (NOS/Other; n =8, 15.69%). Therapist-Participant 4 also made verbalizations that fell into the most coding categories of self-disclosure (5 of 6 codes were applied), when compared to the other therapist-participants.

Analyses indicate that within Session 4, self-disclosures took place slightly more often in non-trauma discussions (NTD, n =27, 52.94%) than during trauma discussions (TD, n =24, 47.06%); as such, it was the most balanced of all 5 transcribed sessions. Within the three identified trauma discussions that took place in Session 4, three codes were applied to therapist verbalizations of self-disclosure (SINV-PERS, SDIS-PERS, and NOS/Other) for a total of 24 codes within the TD, which is similar to other sessions. Personal self-involving disclosures accounted for 75.00% of the TD portions of this transcript (SINV-PERS, n =18), Personal Self-Disclosures accounted for 4.17% (n =1), and Self-Disclosures that are Not Otherwise Specified accounted for 20.83% of TD codes (NOS/Other, n =5). During NTD, five codes were applied to 27 therapist verbalizations of self-disclosure within Session 4 (SINV-PERS; n =17, 62.96%, SINV-MIST; n =3, 11.11%, SDIS-DEMO; n =3, 11.11%, SDIS-PERS; n =1, 3.70%, and NOS/Other; n =3, 11.11%).   This represented the second highest number of self-disclosure codes to be applied within the NTD across all five sessions (T1, n =47).

Self-Involving disclosures. Within Session 4, Self-Involving Disclosures (SINV-PERS) made up 68.63% of overall verbalizations of self-disclosure that were coded and occurred more frequently within the TD (n =18) portions of session, which is similar to that of results found in other sessions. With regards to the TD sections of Session 4, the therapist stated, "Oh my goodness," (T27) in response to the client disclosing that her grandmother lost her eyesight because of glaucoma. Additionally, SINV-PERS was coded for Therapist-Participant disclosures such as, "Yeah I hear you on that … I can feel from that what she must have" (T59) and "I can imagine" (T101) in addition to statements about ongoing work in therapy, like, "You mentioned you wanted to work on some relaxation techniques we'll definitely do that" (T85) and "We're gonna, we're gonna make it better" (T86).

The Therapist-Participant additionally made statements within the TD such as, "Yeah, I know…and you're such a great mom clearly" (T121) in response to the client's verbalization that her kids are very important to her. Several lines later, the therapist stated, "…I know…but you couldn't have known that" (T125) in regards to the sexual abuse her stepdaughter went through, following up with, "we will explore together what it is that you did know" (T127). She also said things like, "I think you made an excellent choice trying to create a sense of normalcy around her" (T130), "I can imagine" (T136), and "I am glad you are taking a second run at dealing with this stuff" (T138). Within the last determined TD (T150-156), the Therapist-Participant stated, "Well we have established that you have a phenomenal social support system" (T155) and "Wonderful. Then our work will be all that much easier" (T156).

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Within the NTD (n =17, which is similar to other sessions) portions of Session 5, many of the early SINV-PERS disclosures made by the Therapist-Participant were related to the fact they were in an intake session, referring to paperwork and clinic procedures (e.g., "Because this is an intake it's gonna be more of a question and answer period so I can get familiar with you" (T6), "I don't know if you know, it sort of discusses with you the laws of confidentiality," (T3) "I know, I know we'll try to get through whatever we can today and finish up next time," (T11) and "We definitely take checks, checks or cash" (T16)). Later, when referencing paperwork again, she stated,

> Right and so we and we look at the we ask those questions for research purposes
> and I'm not sure if you if you checked if it was ok to use your data which is
> completely de-identifying (T105)

and added, "So I'm adaptable to whatever" (T106).

At the end of the first TD (and beginning of the NTD), the therapist changed the topic when she stated, "OK, let me see if I can bang some quick practical questions" (T95). This also occurred at the end of the second TD, when the Therapist-Participant again changed the topic by saying, "... Um, could I ask you a couple of more questions?" (T143). Lastly, at the end of Session 4, she stated, "I think that I have gotten actually everything that I need" (T158), "I am looking forward to getting started and I am going to let you go, because I know you have to…" (T169), and "Okay…I will do my best [to get your fee reduced]" (T182).

The Therapist-Participant made 3 verbalizations of self-disclosure that were related to an admission of mistakes (SINV-MIST), all of which occurred within NTD portions of the session. This represented the highest number of SINV-MIST codes that

were applied to any session across all five coded sessions. These included, "I'm really sorry, but that, that we're right in this room," (T1) "You've got most of them so you need to grab a few signatures a little line on the side all the way through out, I'm sorry," (T3) and "No, I'm sorry. I mean you know well, I'm sure" (T14) in letting the client know that the clinic did not accept credit card payments.

Demographic self -disclosures. Within Session 4, the Therapist-Participant made a total of 3 disclosures (all during NTD) that were determined to fit with the SDIS-DEMO code; out of all five transcribed sessions, this code was applied most frequently during this session (T1, $n =1$; T2, $n =0$; T3, $n =0$; T5, $n =0$). These three demographic self-disclosures included, "I'm a doctoral student in training and I'm overseen by Dr. Lowe," (T3) "It is also because we are training so we try to reach the APACS here," (T10) and "And you're nondenominational, and if you were curious if you were curious yes we are a Christian university, but I don't approach psychology through a Christian lens" (T104). The last example of therapist self-disclosure occurred not as a result of the client questioning the therapist about religious affiliation, but during a discussion about ethnicity and culture in which the therapist spontaneously introduced the topic of religion.

Personal self-disclosures. Within Session 4, the Therapist-Participant made 2 (TD=1, NTD=1) disclosures that were determined to be of a personal nature, which accounted for 3.92% of total overall disclosures. These disclosures included, "It's an area my background expertise in research" (T85, TD) and "…but I don't approach psychology through a Christian lens" (T104, NTD). Session 4 represented the second highest occurrence ($n =2$) of SDIS-PERS codes across all five sessions.

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Self-Disclosures not otherwise specified. There were 8 coded instances of therapist verbalizations of self-disclosure (TD=5, NTD=3) that fell into the NOS/Other category in Session 4, which represented the second highest occurrence of NOS/Other codes across all five sessions. More specifically, of the 51 total disclosures that took place in this session, 5 were coded as incomplete thoughts (n =5, 62.5%; e.g., "I can never begin…" (T54, TD) and "It sounds like, it's, I mean the intergenerationality of it is so massive" (T68, TD). Furthermore, one verbalization was determined to include psychoeducation about therapy (n =1, 12.5%; "Because we learn from our experiences and we make adjustment to our behaviors based on those experiences" (T115, TD), one was about session structure (n =1, 12.5%; "Because this is an intake it's gonna be more of a question and answer period so I can get familiar with you" (T6, NTD)) and one included a therapy facilitative (n =1, 12.5%; "You wanna tell me a little bit about that?" (T25, NTD)).

Session 5. Session 5 involved a female Therapist-Participant and a 28-year-old Caucasian female Client-Participant who identified as Protestant. She reported that she had two children and that she had recently reconciled with her husband after separating from him. She was self-referred to therapy as she reported feeling fearful and overwhelmed, and sought guidance in being able to better manage her emotions. The majority of Session 5 was focused on discussing some of the factors that led to the dissolution of the client's marriage, particularly financial difficulties.

During Session 5, the client discussed her history of physical, sexual, and emotional abuse. She disclosed that when she was four years old, she was sexually abused by her neighbor, which lasted the course of several years. She also reported sexual

abuse by her grandfather and neglect by her mother. She described the impact her trauma history has had on her interpersonal relationships throughout the session. Trauma discussion for session 5 was deemed to include one section (142 talk turns), beginning at T148 and ending at T290.

Of the overall total talk turns (300) that comprised Session 5, verbalizations of therapist self-disclosure were coded 30 times, which accounted for 10.00% of the overall session. This frequency (n =30) represents the lowest number of self-disclosure codes that were coded across all five sessions. More specifically, self-disclosure was coded within three broad coding categories in the Session 5 and three specific codes were applied: (a) Self-Involving Disclosures (SINV-PERS; n =25, 83.33%), (b) Personal Self-Disclosures (SDIS-CON-PERS; n =1, 3.33%), and (c) Self-Disclosures that are Not Otherwise Specified (NOS/Other; n =4, 13.33%).

Analyses indicate that within Session 5, self-disclosures took place more often in non-trauma discussions (NTD, n =17, 56.67%) than during trauma discussions (TD, n =13, 43.33%). Aside from Session 1, this was the only other session during which self-disclosure codes were applied more frequently during NTD than during TD, which occurred in three of the five overall sessions. During NTD, three codes were applied to 17 therapist verbalizations of self-disclosure within Session 5 (SINV-PERS; n =13, 76.47%, SDIS-CON-PERS; n =1, 5.88%, and NOS/Other; n =3, 17.65%). Within the identified trauma discussions that took place in Session 5, two codes were applied to therapist verbalizations of self-disclosure (SINV-PERS and NOS/Other) for a total of 13 codes within the TD.

Self-Involving disclosures. Within Session 5, Self-Involving Disclosures (SINV-PERS, *n* =25) made up 83.33% of all verbalizations of self-disclosure that were coded. In this session, SINV-PERS disclosures were coded slightly more frequently in TD (*n* =13) than in TD (*n* =12).

The following are examples of therapist self-disclosure that occurred within the identified NTD. At the very beginning of Session 5, the therapist stated, "I see you have something" (T1), in regards to something the client brought with her to session. After looking at the document and seeing how organized it was she stated, "Oh my goodness" (T3). Additional verbalizations of SINV-PERS disclosures included, "So I'm excited that's gonna get underway," (T14), "I wanted to just give you the option [of coming in three times a week]," (T15), "Well then we can all arrange that" (T17), "You told me that last week," (T27) "That's really great. I'm, I'm hoping that he continues surprising you" (T32), "I'm glad you have a fridge now it's an important thing to have" (T295), and "Ok well let's go outside, let me get me you, get you those sheets" (T299), as all of these involved therapist verbalizations of personal feelings, thoughts, and reactions about Session 5; all took place at the start and end of the session.

In talk turns 127-129, Therapist-Participant 5 made several NTD disclosures related to her perceptions of the client-participant (which did not occur in any of the other coded sessions) and then asked for her feedback:

That's interesting because I notice there's definitely, I think you change a lot, even from when I meet you in the waiting room to when we come in here. I've noticed… I think in the waiting room I notice I, I feel that you're, it's more of like shy, uncertain [client's name]. You come in here and it's as if you recognize me

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where, oh this is what we do this is, this is where we are together in this room. Um, but when it's out there, it's almost as if we're meeting again for the first time and then to when we get in here it's familiar again. Does that sound like it's accurate? (T127, NTD)

Personal self-involving disclosures accounted for 92.31% of the TD portions of this transcript (SINV-PERS, *n* =12; e.g., "So it sounds like you, I mean, I think that was a very good observation that you liked to" (T183), "I think you mean, I think that's your explanation right there, (T185), and "I know that you said that before that you felt like you're watching it happen" TT262)). Other TD examples included, "Right, I see what you mean" (T204) and "I'm sure that felt very unsafe for you" (T216). Lastly, at the end of session and the TD, the therapist made the following SINV-PERS disclosure to the client, "Well I wanted to thank you for sharing that with me" (T289).

Self-Disclosures not otherwise specified. During Session 5, it was determined that 4 therapist verbalizations of self-disclosure met criteria for the NOS/Other (13.33%) coding category, which is similar to other sessions. More specifically, these consisted of three therapy facilitatives that occurred during NTD (*n* =3, 10.00% of overall session; "I know that Nicky called you, (T13) and "Tell me about that," (T42 and T132) as well as one psychoeducational disclosure (*n* =1, 3.33% of overall session) during a TD (7.69% of Session 5 TD codes):

I mean going back to the issue of control, I think a lot of times, especially when children go through a traumatic thing in their lives and for you it was very, something that was very, completely traumatic but even something that, you know, for a child can be traumatic that might not seem traumatic to an adult, that

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can, it kind of creates an issue where children need control over certain things,

and it goes into adulthood, so maybe not having, maybe someone… (T167)

Personal self-disclosures. Within Session 5, there was one therapist verbalization

of self-disclosure of a personal nature (SDIS-CON-PERS; *n* =1, 3.33%) that occurred

during the NTD. Of all five sessions, this code was applied in only one other session

(T1). It occurred three talk turns before the TD was determined to have begun. During

talk turn T145, the Therapist-Participant stated, "That's a good line. I think I'm going to

use that," in response to the client telling her about something she typically says to her

family members.

Chapter IV. Discussion

Therapist self-disclosure within psychotherapy has long been a controversial topic that is much debated and argued across theoretical orientations. Although some researchers and clinicians argue that the disclosure of personal thoughts, feelings, facts, or experiences can contaminate the therapeutic process, perhaps to the point of being exploitative, others argue that it may serve the function of establishing rapport, instilling client trust, and helping to model appropriate behaviors/ways of coping with stress (Audet & Everall, 2010; Barrett & Berman, 2001; Dryden, 1990; Goldstein, 1994; Peterson, 2002). In fact, some proponents of self-disclosure within a multicultural framework suggest that the sharing of personal and collective experiences can be used specifically to establish rapport, build trust, and reinforce credibility with multicultural clients (Gallardo et al., 2009). While results of studies that examine the use of therapist-self disclosure are generally mixed in terms of the effects that it has on clients, many researchers and clinicians agree on the importance of boundaries and guidelines when using self-disclosure, particularly with clients who have experienced trauma (Goldfried et al., 2003; Harper & Steadman, 2003; Knox & Hill, 2003; Strickler, 2003).

Existing research on the use of therapist self-disclosure with clients who have experienced trauma is limited in nature and mainly hypothetical at this point, with researchers proposing guidelines for clinicians to follow. Additionally, of the scant research that does generally look at therapist self-disclosure (most of which do not take into account the variables of student therapists, trauma treatment, and real psychotherapy sessions), the results are quite diverse, with some studies revealing positive effects of self-disclosure, some revealing negative effects, while others are mixed. The present

study added to the needs of examining student therapist use of self-disclosure within the context of actual psychotherapy sessions with trauma survivors.

In order to accomplish this goal/task, the researcher created a comprehensive coding system that was based on the extant literature on therapist self-disclosure, implemented the deductive coding system, and then employed a qualitative content analysis to examine the coded verbal expressions of student therapist self-disclosure in psychotherapy sessions with clients who had experienced trauma. Specifically, it differentiated between therapist self-disclosure that occurred during trauma discussions versus non-trauma discussions within sessions, a variable that was not investigated in any of the identified past research studies on therapist self-disclosure.

First and foremost, the findings from the present study illustrated the rich and complex nature of therapist self-disclosure. Given that verbalizations of therapist self-disclosure across all four broad coding categories (demographic self-disclosures, personal self-disclosures, self-involving disclosures, and not otherwise specified disclosures) were identified and coded, results supported previous research suggesting that therapist self-disclosure is a multifaceted and multidimensional phenomenon that includes self-disclosing as well as self-involving elements (Audet & Everall, 2010; Bottrill et al., 2010; Knox, Hess, Peterson, & Hill, 1997).

Not only did student therapists use many different forms of self-disclosure, they did so in the context of difficult or traumatic discussions (TD, n =98). Additionally, they evidenced more self-disclosures outside of trauma discussions (NTD, n =113), when discussing topics like intake procedures, client progress in therapy, and scheduling.

Regarding the types of self-disclosure codes found in the present study, student therapists were most likely to use *Self-Involving* (SINV-PERS) disclosures with clients, both during identified trauma discussions within the sessions as well as outside of them. On the other hand, verbalizations of therapist self-disclosure less frequently took the form of *Demographic Self-Disclosures* and *Personal Self-Disclosures,* both of which occurred less often within the identified trauma discussions and more often during non-trauma discussions. Furthermore, there were three *Personal Self-Disclosure* subcodes identified in the coding manual (see Appendix A) that were not applied to therapist verbalizations in any of the five sessions included in the present study (SDIS-CON-DEMO, SDIS-INC-DEMO, and SDIS-INC-PERS).

In sum, these findings shed light on the types and contexts in which student therapist self-disclosure occur during actual therapy sessions with real clients, an area of research that has been varied in methodology, thus making it difficult to compare previous research on the topic. This chapter begins with a discussion of the coded verbalizations of student therapist self-disclosure. Patterns found in the data, both within and across participants, are discussed in context of the current literature. Then, limitations to the present study are presented, followed by a discussion of the contributions of this study. Lastly, implications for future research in the area of self-disclosure are discussed.

Findings Related to Verbalizations of Self-Disclosure

Findings from the present study that utilized real psychotherapy sessions are difficult to compare with nearly all of the previous research on therapist self-disclosure given its varied methodology (e.g., mock therapy sessions, use of different definitions of

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self-disclosure, focused on outcomes or the effect that it has on the therapeutic relationship (Hill & Knox, 2001) rather than frequency and prevalence rates of therapist self-disclosure within psychotherapy). With that said, some comparisons are offered. The frequency rates of therapist self-disclosure found in the present study (mean=15.41%) were similar to the high end of a range reported in a review by Hill and Knox (2001) of some studies (all with varied methodology and non-trauma specific populations) that suggested self-disclosure occurs anywhere from 1-13% (mean of 3.5% across all studies) in judge-coded transcripts of therapy sessions (Barkham & Shapiro, 1986, [3.5%]; Elliott et al., 1987, [5%]; Hill, 1978, [1%]; Hill et al., 1988, [1%]; Hill, Thames, & Rardin, 1979, [1%]; Stiles et al., 1988, [13%]). Hill and Knox (2001) summarized the previous findings when they stated, "it appears therapist disclosure occurs infrequently in therapy" (Hill & Knox, 2001, p. 2).

However, when this researcher reviewed the aforementioned studies cited by Hill and Knox (2001), it was difficult to ascertain the accuracy of the reported range as all of the other studies (aside from Stiles et al., 1988) did not elaborate on their definition of self-disclosure in their methods. In the available articles that utilized Verbal Response Mode methodology to code transcripts for many types of therapist verbalizations (Barkham & Shapiro, 1986; Hill et al., 1988; Hill et al., 1979) clear frequency rates were not reported in two out of six of them (e.g., definitions of SD used in those studies was not reported). The outlier appeared to be the study by Stiles et al. (1988) that reported a mean 13% self-disclosure frequency rates because the next lowest was 5% (Elliott et al., 1987). In the Stiles et al. (1988) study, which examined therapist disclosures in addition to many other types of verbalizations, it was concluded that therapist SD occurred more

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frequently (14.60%) in exploratory (or psychodynamic) sessions than in prescriptive

(11.78%, or CBT) sessions. In that particular study, self-disclosure was one of eight

distinct coding categories (Disclosure, Edification, Question, Acknowledgment,

Advisement, Confirmation, Interpretation, or Reflection), with self-disclosure being

defined as any "I" or "we" statement and the third highest coded category behind

acknowledgments and edifications. The self-disclosure that was coded in Stiles' et al.

(1988) study was similar to the definition of SD used in the present study (except the

present study also used "me"), and the sessions coded were more exploratory in nature.

Therefore, an update to the literature citing self-disclosure frequency rates is needed, as

Hill and Knox's (2001) reported average of 3.5% may not be valid as applied to actual

psychotherapy practice.

Thus, we cannot conclude that SD occurs at a low rate based on the current

research. It has been noted that rates of therapist self-disclosure can be hard to attain

given that immediate self-disclosures in particular are viewed as part of the therapeutic

dialogue, and therefore are customarily omitted from self-disclosure reports, including

studies that are conducted by surveying therapists and clients (Ziv-Beiman, 2013).

Therefore, it is presumed that therapist self-disclosures occur within therapeutic

dialogues at a higher frequency than has been reported in the existing literature (Farber,

2006). The results found in the present study provide mixed support for such

presumptions. Across the five transcribed psychotherapy sessions with clients who had

experienced trauma, overall therapist verbalizations of self-disclosure comprised 15.41%

of overall total therapist participant talk turns, which is just slightly higher than the upper

range reported in previous studies of 13% (Stiles et al.,1988), and much higher than the

upper range finding of 5% (Elliott et al., 1987). The frequency varied across sessions, with one session in the 1-13% range (10.00% of the total talk turns representing therapist verbalizations of self-disclosure in Session 5), 3 sessions just above it (13.88% in Session 1, 14.75% in Session 3, 16.40% in Session 2), and 1 over the range (27.72% in Session 4). All were above the 5% found by Elliot et al. (1987) and four were above the 13% found by Stiles et al. (1988).

Again, since no previous research was identified that investigated frequencies or prevalence rates of therapist self-disclosure within trauma discussions, or within trauma treatment in general, there was no basis for equal comparison using the above reported percentages. Instead, two studies were located that suggested therapists "commonly" disclosed personal background information to sexual abuse survivors in order to connect to them, to balance power, and to instill hope (Fehr, 2010; Harper & Steadman, 2003). In the present study, results indicated that disclosure of personal background information by student therapists was one of the less common forms of self-disclosure (SDIS-PERS and SDIS-CON-PERS; n =14 of 211, 10 of which occurred in Session 1), making up only 6.64% of total self-disclosure codes across all five overall sessions.

Because the data from the present study involved an archival database of transcribed therapy sessions with no access to the Therapist-Participants, there was no way to ask therapist-participants the reasons or intent behind their self-disclosures, as was done by Fehr (2010) and Harper and Steadman (2003). With that said, two of the comments made by TP1 to the client who was a sexual abuse survivor in the context of the game appeared to be about connecting or sharing equally with her; some examples included, "Umm, I guess, something in my life, uh, I have learned that, um, whatever

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that, from my classes I guess" (T31), "Umm, yeah I do feel like getting away…I guess on a vacation (T45), and "I've been um, going to concerts and stuff like that I guess." (T178). On the other hand, the only personal self-disclosure that occurred during a trauma discussion in Session 4, did not equalize power but was an expression of the therapist's power (perhaps said to instill confidence in the client, which could engender hope), when the Therapist-Participant stated, "It's an area my background expertise in research, (T85)" in response to the client asking for assistance in learning some relaxation techniques.

Since neither Fehr (2010) and Harper and Steadman (2003) involved actual psychotherapy sessions with trauma survivors and therefore did not investigate results from a trauma discussion perspective, TD and NTD frequencies and percentages are next related with the aforementioned overall results as a means of comparing data, even if the comparison groups are not similar. When comparing TD percentages with overall findings from the present study, it is evident that therapist self-disclosure occurred slightly less frequently during trauma discussions when compared to the overall session generally (15.19% >13.98%), which is similar to the high end of SD frequencies quoted in the literature. This pattern also occurred in four of the five cases (Session 1; total (13.88%) > TD (10.09%), Session 2; total (16.40%) > TD (14.47%), Session 4; total (27.72%) > TD (21.24%, and Session 5; total (10.00%) > TD (9.15%). In Session 3, however, therapist self-disclosure occurred slightly more frequently in TD-only portions of the session (TT91-269) than it did when compared to the overall average (TD (15.17%) < total (14.75%).

Of note, Session 3 had the highest frequency of coded verbalizations of therapist self-disclosure within the TD ($n =27$) and the second lowest number ($n =14$, Session 2; n=8) of disclosures within the NTD across all five sessions. Therefore, self-disclosure took place less often in Session 3 during the NTD when compared to the overall session (total (14.75%) > NTD (14.00%). At the very start of Session 3, there were a series of NTD therapist self-disclosures that involved the setting of a therapy fee, such as "Um, I wanted to talk about the fee. I want to make sure that you feel that you can pay it" (T4). Then, the Therapist-Participant and Client-Participant spend a significant amount of NTD time (T20-T90) filling out an assessment measure (BDI) together; during that time, only 4 verbalizations of self-disclosure were coded. It is possible that SD was limited during that time as the Therapist-Participant was focused on reading predetermined items from the BDI, during which she tended not to use "I," "me," or "we" language.

There were five additional self-disclosures that took place at the end of Session 3, following the TD that again related to payment for the session. However, aside from these aforementioned disclosures, all remaining verbalizations of self-disclosure occurred within the identified TD (T91-T269, TD=64.04% of overall session). Therapist-Participant 3 verbalized self-involving statements ($n =25$) more frequently than any of the other therapist-participants, which may account for why Session 3 was the only session in which disclosure took place more frequently during the TD than outside of it. Some examples of self-disclosure that occurred within the TD in Session 3 included, "I noticed that you said" (T130), "You feel so upset, I know" (T149), "I remember you said that before" (T151), and:

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 it's, it 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 it's your, you were

saying, that it's your own mom. It's your own mom. But I also feel like I'm kind

of hear 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 (T163)

Conversely, when NTD percentages were compared with overall findings from

the present study, it was evident that therapist self-disclosure occurred more frequently

during non-trauma discussions when compared to the overall session generally (16.92%),

and in four cases (Session 1; NTD (15.21%) > total (13.88%), Session 2; NTD (26.67%)

> total (16.40%), Session 4; NTD (38.03%) > total (27.72%), and Session 5; NTD

(10.76%) > total (9.15%). When selecting for TD-only and NTD-only variables, this

pattern was also true of four sessions: Session 1 (NTD 15.21% > TD 14.47%), Session 2

(NTD 26.67% > TD 16.40%), Session 4 (NTD 38.03% > TD 27.72%), and Session 5

(NTD 10.76% > TD 10.00%). This result pattern indicates that self-disclosure occurred

more frequently (and in rates greater than those quoted in the literature) within NTD

portions of psychotherapy when the TD and NTD variables are accounted for.

(Hypotheses for why Session 3 did not follow this pattern are included in the previous

paragraph).

Therapist verbalizations of self-disclosure occurred most frequently in Session 4

(27.72%, 51 of 184 talk turns), which represented 11.32% more self-disclosure than the

second most frequently coded session (Session 2, 16.40%). When selecting for TD-only

and NTD-only variables, this pattern was also true as frequencies were significantly

higher in Session 4 when compared to the overall average across five sessions (TD

(21.24%) > overall (13.98) and NTD (38.03%) > overall (16.92%)). It is unlikely this

result is due primarily to the amount of talk turns within the TD (n =113) and NTD (n

=71) in Session 4, as was the case in Session 2 (in which most of the session was coded

as TD and very little was coded as NTD). However, when looking at overall code

frequencies across sessions, it can be seen that while Session 4 had the second highest

overall total self-disclosure codes (Session 1 had 58), it also had the fewest overall total

number of talk turns out of all five sessions (TT=184). Therefore, while Therapist-

Participant 4 made a similar number of overall disclosures (n =51) to other Therapist-

Participants, the fact that there were fewer overall talk turns contributed to this higher

percentage as a result.

Additionally, Session 4 had the second highest frequency of verbalizations of

therapist self-disclosure within the TD (n =24) behind Session 3 (n =27), and the second

highest number of disclosures within the NTD (n =27) behind Session 1 (n =47, the

session in which the therapeutic game was played). It was also one of two sessions that

was determined by coded to have included three separate trauma discussions within one

transcript (the other was Session 1). Because it was an intake session, many of the early

non-TD disclosures involved information about clinic procedures, paperwork, and

explaining the process of an initial psychotherapy session, such as when the therapist

stated:

Ok we have a lot to cover too, um so like I said I'm gonna sort of I'm looking

forward to getting to that I just want to take all this in so I know what the context

and the lay of the land is that we're working with…ok so let's go over a little

bit… you told on the intake that something had come up with your daughter that's

bringing some things up for your past. You wanna tell me a little bit about that?

(T24)

This example represented the only instance in each of the five sessions in which the

therapist introduced a direct question about the client's trauma history that prompted her

to begin the TD in Session 4. As research has shown that many trauma survivors are

reluctant to introduce or volunteer information about trauma history unless directly asked

(Read & Fraser, 1998), it is possible that had Therapist-Participant 4 not solicited this

information directly after using statements that was coded for self-disclosure, a trauma

discussion may not have occurred at that point in time. Though not related to literature or

studies on self-disclosure specifically, Briere and Scott (2006) recommended that each

client be assessed for trauma history as part of a complete mental health evaluation (or in

this case, an intake session). It is possible that Therapist-Participant 4's direct

communication style and the timing and nature of the session may have contributed to a

higher frequency of verbalizations of self-disclosure within Session 4.

A discussion of the specific codes and coding categories that were included in the

aforementioned reporting of overall, TD, and NTD coding frequencies is included next

and is tied to the existing literature on the types and categories of therapist self-

disclosure. These coding categories are reported next in the order of coded frequency.

Self-Involving disclosures. While the decision to use self-disclosure as a psychological intervention remains a controversial topic among clinicians and researchers alike, much of the identified literature on the topic is consistent in the agreement that there are different types or categories of self-disclosure that are distinctly separate from one another. Therefore, much of the current research identifies self-involving disclosures, or immediacy statements, as verbal statements made by therapists that reveal feelings or impressions about the client or therapeutic relation in the context of therapy (Bottrill et al., 2010; Knox, Hess, Peterson, & Hill, 1997). In fact, some even go as far to say that self-involving disclosures, those that focus on the client, are the more acceptable form of disclosure as they stem from a relational approach and are less likely to cause boundary transgressions (Audet & Everall, 2010; Myers & Hayes, 2006; Tantillo, 2004). While the present study did not aim to examine outcome or the effects of therapist self-disclosure on the therapeutic relationship, it was clear that self-involving disclosures (particularly SINV-PERS, n =148; SINV-MIST, n =6) were the most commonly used type of self-disclosure that occurred across all five overall sessions (n =154, 72.99% of overall SD). In fact, SINV-PERS was the highest applied code across all five sessions (T3; n =37, T4; n =35, T1; n =27, T5; n =25, T2; n =24). As researchers have traditionally viewed self-involving disclosure as the more "acceptable" form of self-disclosure (Audet & Everall, 2010), it can be inferred from the present study that most, but not all, of the disclosures that took place across all five sessions included personal feelings, thoughts and reactions that arose in and about the therapy.

Within the TD and NTD, self-involving statements that were coded about the therapy (SINV-PERS) occurred quite equally across overall sessions (TD; n =78, 52.70%

and NTD; n =70, 47.30%), a finding which had not yet been investigated in current

literature available on therapist self-disclosure. Within sessions, however, use of self-

involving statements by student therapists varied within both the TD (T3; n =25, 25.51%

of TD codes, T2; n =18, 18.37%, T4; n =18, 18.37%, T5; n =12, 12.24%, and T1; n =5,

5.10%) and the NTD (T1; n =22, 19.47% of NTD codes, T4; n =17, 15.04%, T5; n =13,

11.5%, T3; n =12, 10.62%, and T2; n =6, 5.31%). Some of this variance can be

accounted for across sessions because each individual session had varying overall TD and

NTD talk turns in which self-involving disclosures were coded. For example, in Session

2, within which TD was determined to encompass nearly all of the session (C7-C166, 159

of 189 talk turns), self-involving verbalizations were markedly higher in the TD than in

NTD (18 > 6). However, in Session 4, a session in which TD was determined to be

inclusive of approximately 61% of the session (T25-T95, C106-T143, T150-T156),

SINV-PERS disclosures took place quite equally within the TD (n =18) and NTD (n

=17). Hypotheses related to the amount of code frequencies within the trauma discussion

in Session 4 are included below.

SINV-PERS was overall coded most frequently in Session 3 (n =37). Session 3

had a total of 278 talk turns, which represented the median of all five sessions, and is

therefore not likely a contributing factor to the higher percentage of SINV-PERS codes

that were determined to have occurred. When compared to the overall codes in Session 3

(n =41), SINV-PERS disclosures consisted of 90.24% (n =37) of all codes, with the other

remaining codes (n =4) falling in the NOS/Other category.

This result is suggestive of several observations; first, that Therapist-Participant 3

was more likely than other Therapist-Participants to use self-involving disclosures that

focused on the client and the therapy session (and to do so almost entirely) and second, to have done so without verbalizing any self-disclosing (demographic or personal) information, which all other Therapist-Participants did at some point in session. Though the present study did not examine therapist theoretical orientation in relation to self-disclosure (as such information is not a part of the research database), research has shown that traditional psychoanalytic therapists are less likely to use demographic and personal self-disclosure with clients (Knox & Hill, 2003), as opposed to other theoretical orientations in which these types of self-disclosure is the norm (e.g., feminist therapy). While the specific therapist theoretical orientation is unknown in this case, psychodynamic therapy is an interest of many students who train at the clinic used in the present study.

This also represented the session in which SINV-PERS was coded most frequently within the identified trauma discussion (C91-T269). Within TD, therapist-Participant 3 frequently kept the focus on the client's words and affect. Later in Session 3, she went on to reference some advice she gave in a previous session when she said:

Did you try what we talked about, the other time, did you, remember what we talked about last time, like when you feel angry to, when you walk away [C nods], which is I said a good thing, not a bad thing (T209)

Though the present study was not able to discern therapist intent of self-disclosure, the language used in the first example may be suggestive of Therapist-Participant 3's attempt to both recognize the difficulty and validate the importance of the client discussing her trauma history in session. Research has shown that some evaluators find it helpful to frame trauma assessment in a supportive and non-judgmental context

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(Briere & Scott, 2006), as Therapist-Participant 3 did within the TD. In regards to the second example, some proponents of self-disclosure within CBT treatment hypothesize that normalizing the client's struggles and modeling and reinforcing positive adaptive coping skills can be a useful therapeutic tool (Audet & Everall, 2010; Hill & Knox, 2003). In fact, many suggest that therapists' share personal examples of coping mechanisms that have been successful in their own lives (Dryden, 1990; Goldfried et al., 2003), which may be true of Therapist-Participant 3 noting walking away as a means of coping with anger.

While SINV-PERS tended to occur more often or nearly equally in TD when compared to NTD across all 5 sessions (T3; TD (25) > NTD (12), T2; TD (18) > NTD (6), T4; TD (18) > NTD (17), and T5; NTD (13) > TD (12), a largely opposite result occurred in Session 1 (NTD (22) > TD (5). As described previously, Session 1 involved the use of a therapeutic game that Therapist-Participant 1 and CP1 played from the beginning of session (T8), accounting for the first 11 NTD disclosures in the session. Given that so many NTD disclosures were related directly to the game, it is possible that Therapist-Participant 1's SD and SINV-PERS frequencies would have been much different (lower and in content) had the game not been introduced in the session. There was no research that was located related to the use of self-disclosure during therapeutic games, though it can be hypothesized that this increased the use of personalized self-involving statements in this particular session. Within the TD in T1, the therapist made the following SINV-PERS disclosures, "You told me about your uncle, yeah" (T57), "Like, I'm just wondering, did you become, I mean" (T76), "How about, I don't know if you feel comfortable talking about it" (T91), "I'm sure you don't remember some parts of

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it too" (T233), and "Obviously, I don't know if it happened you know" (T236).

Compared with other sessions (e.g., Session 3), Therapist-Participant 1 made no disclosures within the TD that related to the client's affect/feelings as related to her trauma experience. It appeared she used self-disclosures more of a means to collect information or as a means of clarification, specifically within TD.

Wells' (1994) work was the only identified literature that differentiated any admission of mistakes in therapy by the therapist, such as acknowledging saying something insensitive or inappropriate as its own category of SD. As described earlier, self-involving apologies or admissions of mistakes (SINV-MIST, $n =6$, 2.84% of all SD) occurred within three sessions (T1; $n =1$, T2; $n =2$, and T4; $n =3$). Only one SINV-MIST verbalization was determined to fall at the end of the identified TD in Session 2 ("Okay and I am sorry I didn't return your phone call, I just got your message"), yet did not appear to be related to the TD content that was discussed in Session 2. The other five were part of their respective session's NTD, and all seemed to pertain to logistical issues. Session 4 contained the highest number of SINV-MIST codes ($n =3$) of all five sessions. All three of these verbalizations included apology language by the therapist: "Alright, I'm really sorry, but that, that we're right in this room" (T1), "No, I'm sorry [we don't take credit cards]" (T14), and "I'm sorry about that" (T17). Though it is unknown what the first apology was in direct reference to in Session 4, it was clear that the second and third involved the therapist apologizing for not being able to accommodate the client's desire to pay with a credit card, as it differs from the clinic procedure. The remaining two SINV-MIST disclosures involved admissions of therapist mistakes about the standard protocol for administration of assessment measures used in the clinic: "Just put

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session 7. I should have it done every 5 sessions but it's ok" (T417, Session 1) and "I was supposed to give it to you at the end of last session" (T182, Session 2).

Not Otherwise specified/other disclosures. Because the aforementioned research on self-disclosure tended to discretely differentiate self-involving statements from self-disclosing statements, there was no identified research that took into account whether therapist verbalizations of self-disclosure would fall into neither of these categories. The present study sought to capture any such information with the creation of a NOS/Other category of self-disclosure, and found that such statements occurred less frequently than self-involving statements and more frequently than self-disclosing statements (n =39, 18.48% of total SD). As noted in the results section, four distinct types of disclosure were identified through an examination of themes that emerged as the data was collected within this category: (a) non-specific or incomplete statements (n =21, 9.95%), (b) therapy facilitatives (n =13, 6.16%), (c) psychoeducation (n =3, 1.42%), and (d) comments related to session structure (n =2, 0.94%). Additionally, NOS/Other disclosures were determined to occur rather equally between TD (n =18, 18.37% of TD) and NTD (n =21, 18.58%) portions of the overall sessions.

Session 1 alone had the highest number of coded NOS/Other disclosures (n =19, 9.00% of overall SD). It was observed that Therapist-Participant 1 was more likely than the other therapists to make disclosures that were not self-involving or self-disclosing in nature, and that fell into one of the four aforementioned NOS categories. Within Session 1, non-specific or incomplete self-disclosures accounted for more than half (n =11, 52.38%) across all five sessions. For example, Therapist-Participant 1 would say things like, "I thought, well, do you have something to…no?" (T5), "Oh yeah, it's kind of like

that I guess" (T13), and "I mean, like, you know clients who have been molested…"

(T95), which is indicative of using self-disclosure language ("I" or "me") without having

it be directly related to the client and what was going on inside the room. Therapist-

Participant 1 also made the highest number of disclosures that were determined to be

therapy facilitatives ($n =6$, 2.84% of overall SD). During the course of the session,

Therapist-Participant 1 stated, "Let me see" (T26, T137, T210) and "You know what I

mean?" (T167, T241, T303) three times each, possibly in an attempt to continue to

facilitate a dialogue with the client. It can also be hypothesized that the therapist brought

the therapeutic game into session as a means to help facilitate rapport and dialogue with

this client around difficult subjects, or possibly as a means of easing Therapist-Participant

1's own anxiety about not knowing how to proceed with the client and therefore her

tentative use of self-disclosure language.

Verbalizations of self-disclosure that related to psychoeducation ($n =3$, 1.42% of

overall SD) and session structure ($n =2$, 1.0%) were coded the least in the NOS/Other

category. Although, there was no research identified that investigated frequency of use in

psychotherapy sessions, some researchers who propose trauma treatment CBT models for

the treatment of PTSD and co-morbid disorders stress the importance of both providing

clients with psychoeducation and highly structured sessions (Ford & Hawke, 2012;

Landes, 2013; Triffleman, Carroll, & Kellogg, 1999). Examples of psychoeducation

disclosures included, "A lot of children, when that kind of things happen, they kind of

block it out. I'm sure you don't remember some parts of it too" (T233, Session 1), "Well,

because we learn from our experiences and we make adjustment to our behaviors based

on those experiences" (T115, Session 4), and:

Well it sounds, I mean going back to the issue of control, I think a lot of times,

especially when children go through a traumatic thing in their lives and for you it

was very, something that was very, completely traumatic but even something that,

you know, for a child can be traumatic that might not seem traumatic to an adult,

that can, it kind of creates an issue where children need control over certain

things, and it goes into adulthood, so maybe not having, maybe someone…"

(T167, Session 5)

Lastly, there were two recorded verbalizations that related to session structure in

Session 1 and Session 4. These included, "Let's kind of wrap this up" (T402) and "We'll

try to get through whatever we can today and finish up next time," (T11) respectively. In

both of these examples, the Therapist-Participant phrased the statement using language

that indicated she was referring to both herself and the client ("Let's" and "we'll").

Personal and demographic disclosures. The third and final major category of

self-disclosure, statements that revealed therapists' personal or demographic information,

was determined to occur the least frequently across sessions in the current study. As

Audet and Everall (2010) hypothesized, self-disclosing statements may be more likely

than other forms of SD to cause boundary transgressions due to the fact that they contain

information that is not directly related to the client. Although this could lead us to

conclude that the relative infrequency of this type of SD in our study was, therefore, a

positive thing, the present study's scope did not focus on the outcome or perceived intent

of the use of self-disclosure (as noted previously), such that we can't conclude whether

boundary transgressions occurred. Verbalizations of personal information (SDIS-PERS

and SDIS-CON-PERS) about the Therapist-Participants in the present study occurred in

four of the five overall sessions (SDIS-PERS; n =12, 5.69% of overall SD, SDIS-CON-PERS; n =2, 0.95%), with the majority of these codes being applied in Session 1 (SDIS-PERS; n =9, SDIS-CON-PERS, n =1). The vast majority (94.44%) of personal and demographic self-disclosures were coded within the NTD (SDIS-PERS; n =11, SDIS-DEMO; n =4, SDIS-CON-PERS; n =2) rather than the TD (SDIS-PERS; n =1), suggesting that information that included personal and demographic information about the Therapist-Participants was much more likely to occur during non-trauma discussions in the present study.

Of note, it was proposed in the present study that the specifiers of *consistent* (CON) and *inconsistent* (INC) be added to personal and demographic verbalizations of self-disclosure (SDIS-CON-PERS, SDIS-INC-PERS, SDIS-CON-DEMO, SDIS-INC-DEMO) in order to gain a richer understanding of these codes in relation to the client's experience. Through the process of coding all five sessions, it was determined that SDIS-CON-PERS was the only one of these subcodes that appeared throughout any of the five transcripts; therefore, it is the only SDIS subcode that is discussed in more detail in this section. This particular code is related to Barrett and Berman's (2001) hypothesis that reciprocal self-disclosure can occur when a therapist self-discloses in direct response to comparable client disclosures. The present study revealed that two student therapists working with trauma survivors in psychotherapy did utilize reciprocal self-disclosure, though to an infrequent/small extent (n =2). Though no research was identified in the literature that looked at inconsistent forms of reciprocal self-disclosure, it can be inferred from that present study that it also occurs in psychotherapy quite infrequently, as there were no coded instances in any of the five sessions.

Throughout all of the five transcribed sessions, Therapist-Participant 1 was most frequently coded for verbalizations of personal self-disclosure (SDIS-PERS; *n* =9, SDIS-CON-PERS; *n* =1), meaning TP1 was the most likely of all therapists to reveal personal self-disclosing information about herself in session. Despite the addition of subcodes to the coding manual (CON and INC) that were informed by past literature on SD, a vast majority of the SDIS-PERS codes throughout the sessions were not given these specifiers. Therefore, these verbalizations occurred not in direct response to a personal self-disclosing client statement, but perhaps in response to other personal or contextual variables. Hypotheses for Sessions 1 and 4 are discussed below. Some examples of these verbalizations included, "Whatever that has happened in the past does have an effect on me later, the way I work with things" (T32), "Sometimes I would act really reactively" (T160), "I can kind of look at myself and say, well why did I say that?" (T169), and "I just went to this um concert that's uh, it's this Korean act, person um, it's from East, from Asia" (T179).

In addition to Session 1 having the highest number of overall talk turns of all the five sessions, Therapist-Participant 1 tended to use personal self-disclosure more than other therapists. She additionally was only one of two therapists to be given an SDIS-CON-PERS code, when she stated, "That's where I was coming from too" (T350). This may be seen in light of the therapeutic game that the client and therapist played, which elicited some direct information from TP1 through the cards that she picked up. As can be seen in some of the examples above, TP1 also tended to provide the client with some direct examples of how she has behaved in her own life, in the same way some proponents of CBT advocate for therapist disclosure of personal examples of coping

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mechanisms that have been successful in their own lives (Dryden, 1990; Goldfried et al., 2003).

Outside of Session 1, there were only four verbalizations of therapist self-disclosure that were coded as personal self-disclosures, demonstrating how rarely these disclosures occurred in the current study. In Session 4, the Therapist-Participant verbalized that she had a research background in relaxation and mindfulness, during a conversation with the client about her desire to feel calmer and more relaxed. She additionally introduced information about her theoretical orientation ("Yes we are a Christian university, but I don't approach psychology through a Christian lens" (T104), during a conversation about religion. From these two examples, it can be inferred that TP4 tended to introduce personal information about herself in the appropriate context of the discussion with the client. However, both times TP4 did so spontaneously, and not in response to a direct question from the client. For this reason, it can be hypothesized that TP4 may have therefore disclosed as a countertransference reaction to the client.

Lastly, demographic self-disclosures (aside from SDIS-CON-PERS, which is part of a broader code) represented the least coded disclosure category across all five sessions, with SDIS-DEMO being coded in only two sessions ($n = 4$). Therefore, it can be inferred from the present study that student therapists disclosed demographic information (e.g., age, ethnicity, religious/spiritual affiliation, sexual orientation, marital status, professional credentials) very infrequently with trauma survivors. Furthermore, there were no demographic disclosures made during the TD in any of the five sessions.

Some research has contended that the use of appropriate self-disclosure with culturally dissimilar clients may help them to develop a greater sense of trust in their

therapist when their therapist is able to acknowledge cultural disparities and similarities through the use of self-disclosure (Gallardo et al., 2009; Helms & Cook, 1999). Though the present study did not examine cultural matching of therapists and clients, future research in this area is warranted to gain a better sense of how demographic self-disclosure may affect clients in a multicultural context.

Therapist-Participant 4's highest frequency of verbalizations of demographic information ($n = 3$) appears to be connected with the fact it was an intake session. Examples of this type of SD occurred at the beginning of session when TP4 explained to the client two separate times that she was a doctoral student-in-training working under a licensed clinical psychologist and mid-way through the session when she introduced the fact that her university-based doctoral program is affiliated with a Christian school. This finding is consistent with research that reports some therapists typically disclose biographical information to new clients, such as their professional training, previous experiences, and some demographic information (e.g., marital or parental status) (Henretty & Levitt, 2010; Knox & Hill, 1994). While no research was identified that looked specifically at self-disclosure frequencies within intake sessions, it would not be surprising to find these types of disclosures within such a session, particularly since therapists in the present study were mandated to inform clients of their student status as part of informed consent procedures in the clinics.

The only other instance in which SDIS-DEMO was coded occurred in Session 1, which was previously determined to contain far more SDIS-PERS disclosures than any of the other sessions. This occurred when TP1 responded to a game question ("What would you do if you were told you were going to die soon?") by stating, "I guess I would umm,

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start umm I'd call up my boyfriend and tell him I love him" (T336). The client

responded by stating, "Oh really? That's dope!" Though in this case, TP1 could have

chosen to share any type of information with the client, she chose to share information

regarding her relationship status. Throughout much of the literature on the use of self-

disclosure within psychotherapy, an importance is placed on the utilization of self-

disclosure in response to the client's needs rather than the therapist's (e.g., if they occur

as a result of countertransference and the therapist's desire to serve his/her own needs

above that of the client's). In the current study, it appeared that there were no

"inappropriate" therapist self-disclosures made over the course of the five sessions,

though it could not be determined whether any disclosures were made from a

countertransference stance as there was no access to therapist intent.

Limitations

There were several limitations to the present study and its use of the directed

content analysis method. Regarding sample selection, participants were chosen using

pre-screened (by former PARC researchers) transcribed psychotherapy sessions, which

may have limited the data collected had additional new cases been screened for inclusion

criteria in the present study. Because this study used a convenience sample, it is possible

that individuals who consented to the use of their materials in a research setting may have

differed from individuals who did not provide such consent.

Additionally, despite researcher attempts to use a culturally diverse sample, the

sample only marginally represented a much larger population of clients, with no

information available regarding the cultural characteristics of the Therapist-Participants

other than their gender. All Therapist-Participants and Client-Participants in the present

study were females. Also, four of the five Client-Participants selected and used for the study had experienced childhood sexual abuse, thus limiting the diversity of traumatic events that were experienced. Other demographic information about the therapists may have been useful for examining how the cultural backgrounds of both the client and the therapist influenced the interaction and utilization of self-disclosure between the two. Furthermore, the non-random purposeful sampling procedure and small sample size utilized in the present study limited the generalizability of findings to those not included in the sample. However, from a qualitative research perspective, each participant included in the study had a uniquely valuable experience or perspective; as such, the findings can provide a more comprehensive understanding of the unique and multidimensional nature of self-disclosure use in psychotherapy with trauma survivors through detailed analyses and descriptions (Creswell, 2009; Merriam, 2002; Mertens, 2005).

Because so much past research has focused on the intent or effects of therapist self-disclosure within the context of the therapeutic relationship, comparisons were difficult to make in this regard as the scope of the present study was limited to the "when" and "how" of therapist self-disclosure rather than "why". Due to the fact that data was selected from an archival database with no access to the participants in the study, data concerning "why" therapists chose to self-disclose or how clients received it was unavailable. Despite this limitation, some comparisons still could be made to the scant frequency data that has been cited in previous research and literature.

Another limitation is that the present study may have unintentionally overlooked clients who have experienced trauma because they did not indicate so on any of their

written materials. As such, care was taken to select five pre-screened cases in which

trauma history was evident within the sessions, as a means of being able to further

differentiate between trauma discussions and non-trauma discussions within each session.

In regards to coding procedures, researcher biases will inevitably affect the ways in

which codes are created and assigned to verbal statements (Hseih & Shannon, 2005). In

order to help prevent researcher biases from affecting the coding procedures in the

present study, detailed guidelines and definitions in the coding manual minimized the

impact of such biases. Additionally, researchers met to discuss these potential coding

biases before submission of codes to the auditor, after which inter-rater reliability was

found to be almost perfect for all of the 211 self-disclosure codes.

Yet, focusing on existing theories and research on self-disclosure may have led

the researchers to overlook certain elements of the phenomenon (Hsiu-Fang & Shannon,

2005). Attempts to mitigate such biases were pursued through the use of the NOS

category. Because it was anticipated that some of the verbal statements of therapist self-

disclosure made during therapy sessions would not fit neatly into the categories that were

created based on the review of extant literature on self-disclosure. As such, categories

such as NOS/Other were created so that these responses did not intentionally get removed

from the present study for analysis.

Researchers also considered the fact that some/many individuals may not know or

agree that all "I," "me," or "we" statements qualify as verbalizations of self-disclosure,

particularly since much of the previous research conducted on the subject uses varied

methodology. As such, another limitation of the present study is that student therapist

verbalizations of self-disclosure with trauma survivors may be overrepresented in the

present study due to utilizing a more inclusive definition for self-disclosure. This may, in part, explain why frequency findings from the present study are higher than some of the literature on self-disclosure would report. However, it is believed that the usage of a most inclusive definition of self-disclosure, based on a thorough review of the previous research, would yield the most complex and comprehensive results.

In addition, due to limitations in the research database, the exact timing of the selected therapy sessions in the course of treatment (e.g., whether it was the third session of six overall sessions or the fortieth session of forty-five overall sessions) was unknown for most of the client-participants. Particularly since the therapeutic relationship, the focus of therapy, and level of client distress can change as therapy progresses, having this information could have helped to provide more context regarding the use of therapist self-disclosure in psychotherapy. Additionally, one of the five sessions (Session 4) was an intake session, which may have influenced how the therapist interacted with the client, including the aforementioned reported higher frequency use of demographic self-disclosure that was found in the session as compared to the others. Had all five sessions been intake sessions, more conclusions could have been made regarding the use of student therapist self-disclosure in intake sessions.

Contributions and Clinical Implications

Although trauma has been widely studied, little research has focused on the relationship between trauma and therapist self-disclosure. Past research on therapist self-disclosure has been limited by its methodology because much of it uses mock therapy sessions and inconsistent definitions of self-disclosure. This study specifically aimed to examine trainee therapists' use of self-disclosure (e.g., self-disclosing statements, self-

involving statements, and self-disclosures that were not otherwise specified (a category that was previously un-researched)) in the hopes of better understanding how and when this intervention occurs, as well as which types of self-disclosure are most utilized within actual psychotherapy sessions with trauma survivors. It was found that not only do therapists utilize many different forms of self-disclosure, but also that they do so more frequently than previous research and literature has noted. Not only did the present study explore actual psychotherapy sessions with trauma survivors, but with student therapists, a population that has not received much attention in the past as related to self-disclosure.

Additionally, the present study not only investigated variables that had not been consistently linked with one another in the past (i.e., student therapists, real psychotherapy sessions, trauma treatment), but also aimed to look closely at differentiations in results between new variables such as trauma discussions and non-trauma discussions, which no previous research appears to do. It additionally added to previous research and literature in how self-disclosure is defined and coded. The coding system was shown to be reliable ($K > .81$ for all codes), and could potentially be used by theorists, researchers and clinicians for future work examining therapist self-disclosure. As noted in the aforementioned limitations section, the present study used an inclusive coding system, as all therapist verbalizations of "I," "me," and "we" were identified and coded according to the coding manual (see Appendix A). While this can be seen in light of a limitation in that it differs from previous research, thus making comparisons difficult, it can also be seen as a contribution to the field, which may change the way that others consider how SD is viewed and studied.

Specifically, three broad coding categories (self-involving, self-disclosing, and disclosures not otherwise specified) were created to comprehensively capture verbalizations of therapist self-disclosure. Then, based on a thorough review of literature, subcodes were created (CON and INC) within the self-disclosing category in order to more accurately capture self-disclosure within the sessions; yet, therapists infrequently disclosed consistent personal information to clients, and did not verbalize inconsistent disclosures. Furthermore, within the self-involving category of codes, one code (SINV-MIST) was created for the present study that had not yet been investigated in any of the previous literature available on self-disclosure; while infrequent, admissions of mistakes or therapist apologies occurred in three of the five sessions.

The present study additionally looked at self-disclosure that did not fit into the "traditional" categories of self-disclosure (by examining NOS/Other data), thereby identifying several new areas for self-disclosure research. In fact, four distinct types of NOS/Other disclosures were identified through an examination of themes that emerged as the data was collected within this category: (a) non-specific or incomplete statements, (b) therapy facilitatives, (c) psychoeducation, and (d) comments related to session structure. Of note, while some of the previous research on therapist self-disclosure alludes to "positive" and "negative" self-disclosure, these themes did not emerge during the NOS analysis. "Positive" and "negative" subcodes were also eliminated from the coding manual during pilot coding because it was determined that they were far too subjective to accurately and reliably code.

It was determined that verbalizations of therapist self-disclosure occurred across all four broad coding categories (demographic self-disclosures, personal self-disclosures,

self-involving disclosures, and not otherwise specified disclosures), in rates higher than had been previously reported in nearly all literature on therapist self-disclosure. In fact, when the researcher in the current study looked more closely at the studies that had been commonly cited for self-disclosure frequency data, it was found that much of the research referenced did not cite frequency rates, other than two that were able to be located (5% and 13%). Therefore, there appears to be a current need to correct misperceptions or erroneous reports about past literature. Because the frequency rates that were found in the present study may actually be much higher than all previous research that investigated therapist self-disclosure, there is an opportunity to add to the existing literature and demonstrate that SD may occur more frequently than was previously thought, while taking into account different methodologies.

The present study also determined that student therapists commonly used many different forms of self-disclosure in psychotherapy with trauma survivors, both in trauma discussions and outside of them. Overall, self-disclosure occurred within the TD and NTD at rates higher than reported in previous literature on general self-disclosure; as previous research may actually underestimate rates of self-disclosure, these frequency rates in the present study might additionally be much higher by comparison. Additionally, it may help to dispel assumptions that the use of self-disclosure in trauma treatment may be inappropriate or as occurring strictly as a result of the therapists' countertransference towards the client. Throughout all of the sessions, there were very few demographic or personal disclosures made within the trauma discussions, suggesting that the therapists tended to keep the focus on the client's thoughts, feelings, and experience. In both TD and NTD across all five sessions, there were no disclosures related to the therapists' own

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trauma, a practice that is controversial in trauma literature. As no previous research was identified that investigated frequencies or prevalence rates of therapist self-disclosure within trauma discussions, or within trauma treatment in general, this represents a major contribution to research on therapist self-disclosure in trauma treatment.

Regarding clinical implications, many student therapists or even licensed professionals may be unaware that they are using self-disclosure with clients, particularly self-involving disclosures, as these have been differentiated throughout much of the literature as the less stigmatizing form of disclosure. Similar to how Ziv-Beiman (2013) posited that immediate self-disclosures in particular are viewed as part of the therapeutic dialogue, and therefore are customarily omitted from self-disclosure reports that surveyed clients and therapists, bringing this distinction to light may help mental health practitioners be more aware of their language in the room. Additionally, discussing the topic of self-disclosure, as noted a controversial topic throughout history, individuals can begin to more actively think about their own use of self-disclosure with clients, including reflection on their own personal boundaries and intent for disclosure.

This study also has implications for training and supervision, given that it elucidated the use of self-disclosure in trauma treatment by student therapists who work under the license of their supervisors. More specifically, if self-disclosure is happening more frequently than previously reported, it raises questions about whether self-disclosure is a topic that is, or should be, regularly discussed and reviewed with students-in-training, particularly since many students are being exposed to different theoretical orientations throughout graduate school and may be unclear in how self-disclosure affects their clients and the therapeutic relationship. Because we know that self-disclosure

occurs in many different forms (e.g., demographic, personal, self-involving and other), student therapists would benefit from education on how and when to use therapist self-disclosure with clients, and specifically with those who have been through adverse life experiences like trauma. For example, students could be taught to judiciously use self-involving statements with clients that focus on the here-and-now, by reflecting their thoughts and feelings back to them in sensitive ways. Additionally, since it was determined that demographic disclosures occurred most frequently during the intake session, intake/clinical interviewing classes could teach students about the different types of self-disclosure that are required to be shared in intake sessions and help students form guidelines about what to do when clients solicit personal information about them at the start of treatment. This finding holds potential implications for future supervision practices, particularly with students in training.

Directions for Future Research

In order to fully understand the multifaceted and complex types and functions of the use of therapist self-disclosure in psychotherapy, further directions for research in several areas is offered. First, research should continue to focus on identifying and understanding different forms and categories of self-disclosure. More specifically, continued research using the coding system and the definition of SD used in the present study could gather data on the different forms and types of self-disclosure that were identified in the present study as well as those codes that were not found (e.g., CON and INC subcodes, further examination of NOS/Other codes and potential sub-categories other than the four that were identified) with different populations of student-therapists (e.g., beginning versus advanced graduate students) who are in real psychotherapy

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sessions with clients who have and have not experienced trauma. They could also take into account the timing of the sessions to determine self-disclosure frequency rates across different points in the therapeutic relationship (e.g., intake, mid-treatment, termination), and examine how SD affects the therapeutic relationship and other outcomes within psychotherapy (e.g., client levels of trust, duration of treatment), variables that was not looked at in the present study.

Additionally, future studies could attempt to validate the current coding system by comparing the codes with other ways that self-disclosure has been measured by those who have studied therapist self-disclosure in the past. Because many of those studies used mixed methodology, a future area for research also includes creation of a standard self-report measure for specifically measuring therapist self-disclosure, which may also include open-ended questions with regard to intent of self-disclosure. Furthermore, therapist intent could be explored more fully by running studies in which student therapists watch or listen to videotaped sessions of themselves employing self-disclosure in psychotherapy sessions and responding to a series of questions regarding their reasons for self-disclosure in those moments. Studies such as these would add significantly to research on therapist self-disclosure and may help to answer theoretical questions such as how therapist self-disclosure is related to countertransference responses.

Furthermore, future trauma-related self-disclosure research could also be enhanced with the addition of comparisons of SD use within and out of trauma discussions and/or with clients who have experienced trauma as opposed to those who have not. Because self-disclosure can be a misunderstood construct in that literature (in that SINV-PERS statements are often viewed as part of the therapeutic dialogue and are

therefore traditionally not seen as self-disclosure) and/or clinicians have traditionally viewed it as damaging and occurring a result of the therapist's own countertransference in an attempt to fulfill their needs above the client's needs, future studies could continue to investigate self-disclosure use with different types of populations, particularly those that are considered at-risk.

More specifically, future studies could continue to investigate frequency rates of the different categories of self-disclosure to determine whether the rates in the present study could be replicated or whether they would differ. Additionally, as the present study is the only identified study that investigated therapist self-disclosure with trauma survivors, future studies could continue to investigate self-disclosure with trauma and other populations. In fact, future research could look at self-disclosure in context of different types of trauma populations (e.g., sexual abuse survivors, hate crimes, environmental disasters) to determine whether frequency rates and self-disclosure content changes based on those variables. In fact, the present study could be used as a basis for future studies on trauma treatment, in that it made clear that there were portions of the session that were determined unanimously by all three researchers and their auditor to be inclusive of a trauma discussion.

Also, as the results from the present study were based on only five participants and psychotherapy sessions, research could benefit from future studies that utilize a greater number of socioculturally diverse participants with a wider range of trauma histories. With a greater number of participants, it may be possible to assess for differences in the use of therapist self-disclosure by type of trauma experienced (if at all) by clients and therapists, and to gain a richer understanding of sociocultural differences in

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the use of SD (e.g., gender; ethnicity). Additionally, more participants would allow researchers to look at a wide variety of other specific therapist characteristics (e.g., theoretical orientation, cultural affiliation) as well as psychotherapy sessions, and allow for analyses and comparisons by session type (e.g., intake, termination, mid-treatment). Future studies could then compare the forms and frequencies of self-disclosure used at different points during the course of therapy, or between therapists and clients of the same or different cultural groups.

Another possible direction for future research involves the development of guidelines for therapists regarding self-disclosure use in therapy. For example, it could include information and examples regarding how to utilize self-involving statements more often than self-disclosing (personal and demographic) statements within psychotherapy sessions. While some research has discussed this idea in the past, a manual for student therapists could be developed based on existing literature (e.g., Garrett, Garrett, Torres-Rivera, Wilbur, & Roberts-Wilbur, 2005; Dozois et al., 2009), including (a) Conceptualization of self-disclosure through various theoretical lenses; (b) The risks and benefits of therapist self-disclosure, and (c); When to self-disclose and when not to. A manual like this could then be given to masters and/or doctoral-level therapists-in-training and tested for effectiveness in control studies. For example, a study could be conducted to compare outcomes (e.g., self-reported psychological symptoms and/or therapeutic alliance) using this newly developed manual to treatment as usual.

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APPENDIX A

Coding Manual

RESEARCH PROJECT CODING MANUAL

This training manual is intended to describe the methods of participant selection, transcription, and coding that will be utilized for the team's dissertation research projects. The specific videotaped therapy sessions will be of clients and therapists at Pepperdine University GSEP clinics selected based on inclusion/exclusion criteria (e.g. individual adult clients representing diverse ethnicities, genders, religions, and presenting issues). Krista Kircanski, Courtney Bancroft, and Roxanna Zarrabi will be using this data for their respective dissertations to gain a more in-depth understanding of how therapists who provide trauma treatment use self-disclosure, elicit gratitude and provide validation/invalidation with their clients. Research assistants will also assist in the participant selection and transcription processes, including the identification of discussions of trauma within videotaped psychotherapy sessions.

I. PARTICIPANT SELECTION AND IDENTIFICATION OF TRAUMA DISCUSSION: INSTRUCTIONS

Participant Selection Procedures

Step 1. Review the list of pre-screened cases (those that have been used in former PARC research teams) for inclusion criteria (individual therapy clients who are over 18 and English-speaking; clients reported experiencing a traumatic event(s) or experience(s); those who had at least one videotaped session in which there was a discussion of trauma, defined as any first-time or ongoing verbalization that includes the following: (a) descriptions of a traumatic event, the decision to disclose/discuss it, and the outcomes of disclosing (e.g., positive or negative) (b) evaluative or cognitive content about the traumatic event, the decision to disclose/discuss it, and the outcomes of disclosing (e.g., positive and/or negative beliefs, thoughts, attitudes); (c) affective content related to the traumatic event, the decision to disclose/discuss it, and the outcomes of disclosing (e.g., positive and/or negative feelings and/or emotions regarding the traumatic event) (Chaudoir & Fisher, 2010; Chelune 1979; Jourard, 1971; Pennebacker, Zech, & Rime, 2001)). As described in the literature review, the definition of a traumatic event was based on current DSM-5 (APA, 2013) criteria (below), cultural recommendations and complex trauma:

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: 1) directly witnessing the traumatic event(s); 2) witnessing, in person, the event(s) as it occurred to others; 3) learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental; and 4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse; note: this

criterion does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related; p. 271).

The individual who experienced the trauma must have done so in a direct manner, either by witnessing or experiencing a threat to physical integrity, such as serious accidents or fire, life threatening combat experiences, rape or physical assault, life threatening major disasters, and seeing another person being killed or badly hurt (First et al., 2002). Threats to physical integrity related to cultural or race-based factors included hate crimes involving threatened or actual assault and those related to complex trauma are prolonged and cumulative in nature, such as repeated childhood physical or sexual abuse, human trafficking, and domestic violence.

Step 2. In the case that at least five sessions from the pre-screened cases are not appropriate for the present study, researchers will obtain a complete list of research record numbers of all de-identified clients and screen the exiting database for cases that identify trauma within the written intake.

Regarding the written materials, researchers could use several data instruments located in the de-identified research files to assess for the occurrence of a traumatic event. The researchers would first look at the information presented on the Client Information Adult Form (Appendix B). In this section, the client is asked to mark off "Which of the following family members, including yourself, struggled with," and is provided with a comprehensive list of distressing and potentially traumatic situations. These include, but are not limited to, death and loss, sexual abuse, physical abuse, and debilitating illness or disability. The researchers would look to see if the client marked "Yes - This Happened" in the "Self" column for the aforementioned stressors. Additional information from the Telephone Intake Form (Appendix C), the Intake Evaluation Summary (Appendix D), and the Treatment Summary (Appendix E) would also be used to determine whether clients have experienced traumatic experiences involving a threat to physical integrity.

Step 3. Further narrow the sample to those who have at least two videotaped sessions in which there was a discussion of trauma, defined as any first-time or ongoing verbalization that includes the following: (a) descriptions of a traumatic event, the decision to disclose/discuss it, and the outcomes of disclosing (e.g., positive or negative) (b) evaluative or cognitive content about the traumatic event, the decision to disclose/discuss it, and the outcomes of disclosing (e.g., positive and/or negative beliefs, thoughts, attitudes); (c) affective content related to the traumatic event, the decision to disclose/discuss it, and the outcomes of disclosing (e.g., positive and/or negative feelings and/or emotions regarding the traumatic event) (Chaudoir & Fisher, 2010; Chelune 1979; Jourard, 1971; Pennebacker, Zech, & Rime, 2001).

If there are more than two disclosures or discussions of trauma that occur across sessions, the two sessions per client will be chosen based on timing of the discussion in therapy (i.e., an early or intake session and a session from the end of treatment) and discussion length (i.e., the sessions in which the client discussed the trauma for the longest length of time compared to other sessions will be chosen). The rationale for this proposed method is to facilitate gathering data about different types of self-disclosure, as clinical intuition suggests that more demographic self-disclosing (SDIS) statements may

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be made during intake sessions whereas more self-involving (SINV) personal statements may be made in later sessions as the therapeutic relationship strengthens. Additionally, the review of literature on therapist self-disclosure suggests that therapists and clients report an increase in self-disclosing (SDIS-DEMO and SDIS-PERS) statements during intake and termination sessions, which will be reviewed for inclusion in the present study (Gibson, 2012; Henretty & Levitt, 2010; Knox & Hill, 1994; Rabinor, 2009; Roberts, 2005; Sparks, 2002).

Step 4. Of these participants, specific client characteristics and demographics will be analyzed in order to obtain a diverse sample (see Appendix F). The researchers should attempt to choose culturally and demographically diverse participants who vary in age, gender, religion, and race/ethnicity. Specifically, there should be no more than four clients that identify with each of these demographic categories/groups. The chosen sessions will be transcribed and the entire session will be coded.

II. CODING OVERVIEW

The second step of the process involves the researcher-participants engaging in the coding processes, specifically for A. self-disclosure, B. expressions of gratitude, and C. positive/negative responses to trauma. Operational definitions and relevant codes are discussed in this section.

A. Self-disclosure

For the purposes of this study, self-disclosure is defined as verbal statements (non-verbal cues are not coded) through which therapists intentionally communicate information about themselves to their clients (Hill & Knox, 2002) in two main categories: 1) self-disclosing statements, factual statements, and personal disclosures (SDIS) that can further be divided into consistent and inconsistent subcategories, and 2) self-involving or immediacy statements (SINV), resulting in the following classification categories: SDIS-CON: Self-disclosing consistent statements (reciprocal statements made by the therapist that are neither demographic nor personal in nature but are consistent with or is linked to the client's verbalization), SDIS-INC: Self-disclosing inconsistent statements (reciprocal statements made by the therapist that are neither demographic nor personal in nature and are inconsistent with the client's verbalization), SINV-PERS: Personal feelings, thoughts and reactions that arise in and about the therapy**,** and SINV-MIST: Therapist disclosures that involve any admission of a mistake by the therapist. In addition, a category of NOS/Other was created to capture statements that occur when the therapist makes a verbal statement that does not include demographic or personal information about the therapist and does not involve personal feelings/reactions to therapy nor admission of mistakes. The following coding system will be used to record trainee therapists' use of self-disclosure during the discussion of trauma in psychotherapy:

Demographic and Personal Therapist Expressions of Self-Disclosing Statements

Codes	*Demographic Disclosure*	*Personal Disclosure*

	(Code DEMO)	(Code PERS)
	The therapist makes a verbal statement that includes demographic information (e.g., age, ethnicity, religious/spiritual affiliation, sexual orientation, marital status, professional credentials). Can be coded SDIS-DEMO alone if it is unclear whether the disclosure is consistent or inconsistent with the client's experience.	The therapist makes a verbal statement that includes personal information (e.g., hobbies, leisure activities, trauma history, medical illness, death in family, personal discrimination, political beliefs, relationship history, experiences in the mental health field). Can be coded SDIS-PERS alone if it is unclear whether the disclosure is consistent or inconsistent with the client's experience."
	Examples: "I'm in my third year in a doctoral program in clinical psychology."	Examples: "I had to cancel our last session because my son was sick and I couldn't find a babysitter."
	"I'm African American" [client's ethnicity in unknown]	"I saw that on the news."
Consistent Self-Disclosure (Code SDIS-CON)	(Code SDIS-CON-DEMO) The therapist makes a verbal statement of a demographic nature that is consistent with or is linked to the client's experience following the client's disclosure. CON would not be coded if the therapist disclosed first. Examples: "I'm also working on my doctorate." "I liken your experience in the army to mine with my children."	(Code SDIS-CON-PERS) The therapist makes a verbal statement of a personal nature that is consistent with or is linked to the client's experience following the client's disclosure. CON would not be disclosed if the therapist disclosed first. Example: "I felt some of the same things when I was going through a death in my family." "Your experience of camaraderie is deeply reminiscent of my bond with my siblings growing up."
Inconsistent Self-Disclosure (Code SDIS-INC)	(Code SDIS-INC-DEMO) The therapist makes a verbal statement of a demographic nature that is incongruous with the client's experience following the client's disclosure. INC would not be coded if the therapist disclosed first.	(Code SDIS-INC-PERS) The therapist makes a verbal statement of a personal nature that is incongruous with the client's experience following the client's disclosure. INC would not be coded if the therapist disclosed first.

	Example: "No, I don't have kids [client has kids]."	Example: "I haven't struggled with drug addiction myself and can only imagine what you're going through."

Therapist Expressions of Personal Reactions and Mistakes

Codes	*Personal Reactions Disclosure (Code SINV-PERS)*	*Mistake Disclosure (Code SINV-MIST)*
	Personal feelings, thoughts and reactions that arise in and about the therapy that are complete and/or specific. Structural comments about the therapy process are coded here. "I," "we," and "me" are coded for in this category, but not "you" or therapy facilitatives. Examples: "I'm struck about something you said." "And, my gosh." "I'm feeling very hopeful about the plan we collaborated on." "We've come a long way together." "I'm feeling sad as you tell me this." "I'd like to hear more about that." "I'm thinking about it this way, which maybe might make sense to you also." "I love that idea." "I wanted to give you the option of coming in two times a week." "I know you like to help others" "I see you brought something in today." "I'm concerned about your lack of consistency in attending appointments." "One thought I had was, going back to the strength thing… [thought is complete/specific]" "I'm worried that you're not being honest with me."	Therapist disclosures that involve any admission of a mistake by the therapist. Example: "I made a mistake." "I'm sorry for being late." "You're right, maybe I misunderstood what you were trying to tell me." "I was seriously only two minutes late." "Sorry about that."

"I'm very struck by the fact that you saw people get killed yet you feel very little emotion about it."

"I'm disappointed you didn't attend our last session."

"You're the most beautiful client."

Therapist Expressions that are Not Otherwise Specified

Code	Description	Examples
Other Disclosure (Code NOS/Other)	The therapist makes a verbal statement that does not include demographic or personal information about the therapist and does not involve personal feelings/reactions to therapy nor admission of mistakes. "I," "we," and "me" are coded for in this category, but not "you" or general niceities (e.g., "Thank you."). Psychoeducation related to what has been gained through experiences in the mental health field could be coded here. For example, "You may experience flashbacks with PTSD." Additionally, self-involving statements that refer to the session structure can be coded here. For example, "I think we're out of time" and "We have two minutes left." Non-specific and/or incomplete verbal statements are coded here as well as therapy facilitatives (e.g., "I see," "I understand," and "Tell me about that")	T: "I'm just really hungry/thirsty." C: "Did you cut your hair recently? It looks different to me." T: "I cut it three weeks ago, actually." T: "I'm not saying let it all out at once…" T: "In that way, we can better help people around us." T: "That is so typical of what we see in clients who have experienced trauma." T: "Coz typically it's hard for people to overcome the PTSD without sharing their emotions and feeling them." T: "Could you turn your phone off? It's very distracting to me." T: "I see that you got a haircut." T: "I'm wondering if the journalist could trigger this is you because you don't have the camaraderie with that journalist?" T: "One thought I had was…. [thought is incomplete/non-specific]" T: "It's kind of like that I guess…"

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		T: "I see."
		T: "I understand."
		T: "Tell me about that."

B. Gratitude

For the purposes of this study, gratitude is defined as a broad trait (i.e., gratitude for relationships, God or higher power, life or nature, not directed towards a specific individual) or as a narrow cognitive-emotional state experienced specifically (i.e., directed toward particular individuals, God, or a higher power for benefits received, which may manifest in a desire to engage in reciprocity behavior or in other specific actions (e.g., seeking social support as a way of coping). Two general categories were created: 1. *Gratitude as a broad, general tendency or trait* **(Code GB)** is operationally defined as a general tendency and characteristic of an individual to approach and respond to most circumstances with appreciation and thankfulness, and 2. *Gratitude as a narrow state* **(GN)** refers to gratitude as a state, emotion, and mood that arises temporarily as a response to receiving gifts or benefits **(material or nonmaterial)** from a specific person or people.

To assess gratitude in the context of recorded and transcribed psychotherapy sessions, only verbal expressions of gratitude will be examined. Words that are typically used to signify gratitude include grateful, fortunate, thankful, lucky, blessed and appreciative, and will be required to code for the categories described below (with the exception of G-NOS/OTHER). However, coders should carefully consider whether a gratitude code should be given if the client uses a gratitude word (e.g., "I should be feeling appreciative, but I'm not") or its opposite/converse (e.g., "unlucky", "unfortunate").

In addition, words that describe a desire to reciprocate include but are not limited to: repay, reciprocate, and owe and will be coded accordingly.

Client Expressions of *Gratitude as a Broad, General Tendency or Trait* (Code GB)

Codes *Gratitude as a broad, general tendency or trait* **(Code GB)**	Description	Examples
Generalized gratitude as an attitude (GB-1)	Generalized gratitude is referred to as a component of trait or dispositional gratitude and is an attitude towards life that indicates being grateful in most circumstances and displaying a tendency to be grateful generally	C: "I am so grateful for my mother, she is amazing,"

	for something or someone.	
Transpersonal gratitude (GB-2) **Subcode: Undeserved kindness (GB-2u)** **Subcode: Gratitude for the present moment (GB-2p)**	Transpersonal or universal gratitude typically results from peak experiences that can include nature or spirituality and are typically characterized by a sense of undeserved kindness Subcode GB-2u: This subcode will be given when client expressions of gratitude include a sense of undeserved kindness. The subcode GB-2p will be used when the client expresses gratitude for the present moment.	C: "It took a long time for me to acknowledge my higher power in AA, but I'm so glad/thankful I got there;"C:"During the trip I felt overwhelmed by thankfulness that I had the opportunity to enjoy all these wonderful things without even deserving too." C: "I am grateful for this present moment right now."

Client Expressions of *Gratitude as a Narrow State (GN)*

Codes *Gratitude as a narrow state (GN).*	Description	Examples
Personal gratitude (GN-1)	Personal gratitude is defined as thankfulness towards another person for the benefit he/she has given to this person.	Example: "I feel blessed that Martha wrote that letter of recommendation for me." Example: "Thank you."
Gratitude for specific benefits received from a higher power (GN-2).	Personal gratitude towards God or another higher power.	Example: "God has provided me with a wonderful social support system, for which I am so grateful."
Gratitude outcomes (GN-3) *Reciprocation (Secular) (GN-3-RECIP).*	Gratitude outcomes include results that occur after gratitude experiences or practices. These results may include: 1) an individual's desire to engage in reciprocity or helping behavior as a result of benefits received, and/or 2) changed perceptions of self and others in regards to skills developed as a result of adversity and/or as a result of enduring adversity, as well as 3) **seeking or receiving** social	Example of GN-3: "When I end my day by counting my blessings, I fall asleep so quickly and feel peaceful" Example involving subcodes: "I've realized after the loss I experienced that people can be relied on for support, which has made me grateful and has motivated me to return the favor by supporting others when they need somebody to talk to."

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	support as a means of coping - as reflected in the following subcodes.	Example: "I'm so grateful that Emily spent hours helping me with my homework, so I'm going to repay her by bringing her favorite dessert to school."
Prosocial Behavior GN-3-PROSOC	GN-3-RECIP: This code will be given when the client expresses gratitude towards the benefactor for a benefit received as well as a desire to engage in reciprocity behavior. GN-3-PROSOC:This code will be given when the client expresses gratitude for benefits received as a motivator for altruistic behavior (e.g., offering emotional support to others, helping others with personal problems), that is not directed towards the benefactor.	Example: "I am so thankful for the support my therapist has given me that it motivated me to volunteer at a crisis hotline so I can help others in need."
Changed perceptions of self and others (GN-3-POS).	GN-3-POS: This code will be given when the client expresses gratitude that is a result of changed perceptions of self and others in regards to skills developed as a result of adversity and/or as a result of enduring adversity, and/or when the client expresses gratitude that results from seeking social support as a means of coping.	Example: "I learned through this difficult time that I have so much support, that others care for me and I will continue to seek their support as it has helped me tremendously and I'm so grateful for that." Example: "I'm so thankful for my mindfulness group because it helps me get through my day". Example: "The divorce was very difficult but without it I would have never realized how strong I am on my own, so I'm thankful for that."

Client Expressions of Gratitude That Are Not Otherwise Specified

Codes	Description	Examples
Gratitude expressions that are not otherwise specified (Code G-NOS/OTHER)	Expressions of gratitude that do not include a gratitude related word and/or are not included in any of the aforementioned categories.	Example: "Steve was able to talk with his employer and get me an interview at ABC. I really want him to know how much that meant to me, so I'm going to take him out to dinner this week." Example: "He told me I looked thin and I thought gee thanks, what did I look like before?"

C. Positive/Negative/Neutral Responses to Trauma

The researcher-participants coded therapist-participant responses and reactions to a traumatic disclosure or discussion by the client-participant. For the purposes of this current dissertation, any verbalizations in reaction or response to a discussion of trauma (positive, negative or neutral) were coded and analyzed in the context of psychotherapy sessions, and were later separated by trauma discussion sections (TDS) or non trauma discussion sections (NTDS).

Responses and their definitions and examples are presented in the table below for the researcher-participant to use in coding the transcribed sessions. Given the complex nature of how an individual may respond to hearing about a traumatic event, codes were created based on extant research and include those responses that can be objectively measured via videotape/transcript. Therefore, the responses were coded as either (a) Positive Responses, (b) Negative Responses, or (c) Neutral Responses. More specifically, they were then coded into subcategories, as either (a) validating responses, (b), supportive responses, (c), empathic responses; (d) invalidating responses, (e) unsupportive responses, (f) unempathetic responses; (g) clarifying questions, or (h) summary/reflection statements. As responses were recorded, data was gathered by identifying the subcategories as certain types of examples, listed below in the tables. Furthermore, two types of adjunctive codes were added; (i) missed opportunities, (j) clinical responses.

Across all categories, + signs will be added as an addendum to each code represented below when there is a clear missed opportunity for a positive response (e.g., therapist changes the subject after client attempts to talk about or process trauma; or therapist focuses strictly on content after client expresses affect; etc.) Additionally, an * will be used for instances in which the therapist-participant uses clinical terminology or psychoeducation when speaking to the client about the traumatic event or presentation (e.g., recovery, symptom presentation, or treatment).

Positive Responses (Codes POS1, POS2, POS3)

Codes	Description	Example
Validating Responses (POS1)	Instances of the therapist-participant expressing a statement (not question) relating understanding and/or acceptance of a client's thoughts, feelings and behaviors related to the traumatic event. This includes the therapist expressing understanding/acceptance in the form of a reflective statement as well, as long as that reflection is deemed a	Understanding: C: [verbalizes feeling upset about traumatic event] T: "I understand how someone would be upset by that" Acceptance: T: "what you went through was difficult," Validation via Complex Reflection: C: Sometimes when I'm

	"complex" reflection; as defined by either paraphrasing, which is when the clinician reflects the inferred meaning of a statement (meaning is added on to what was actually said by the client); or by reflection of feeling, which is when the clinician using paraphrasing to focus on the emotional aspect of the statement; both of which add new meaning to the client's statement, showing understanding and acceptance of the deeper meaning of what the client has said. [If both a "simple" reflection and validating response, only validating response would be coded, not NEU2- see NEU2 criterion]	going about my day, it feels like I'm right back in that war zone. T: Even throughout a normal day, you might feel as unsafe as when you were at war and this can be very frightening for you.
Supportive Responses (POS2)	Includes encouraging responses of the therapist-participant and/or those that advocate for and empower the client.	Encouraging: T: "I'm glad you're talking about this," "Go on," or "Tell me more" Advocacy/Empowerment: T: "You deserve to be at peace with this," or "You are very strong for having gotten through this"
Empathic Responses (POS3)	Those in which the therapist-participant verbalizes **using "I statements"** how s/he is able to imagine that s/he is the other person who has experienced the situation. Including; expressions related to personal	Feelings: T: "I would have been very afraid" Thoughts: T: "I would have been thinking the worst in that situation" "I could imagine that experience would have

| | disclosures by the therapist-participant regarding his ability to engage in the experience as if he actually had the feelings, thoughts, and behaviors of the survivor; and expressions related to the therapist inferring or imagining what it would be like to have had those thoughts, feelings, and behaviors of the survivor. | been difficult"

Behaviors:
T: "I would have wanted to run away" "I'd imagine that if I were in that situation, I would want to escape." |

Negative Responses (Codes NEG1, NEG2, NEG3)

Codes	Description	Example
Invalidating Responses (NEG1)	Instances of the therapist-participant meeting the disclosure with an inappropriate, punishing, trivializing, or judgmental response, and/or meeting the disclosure with a dismissive response.	Inappropriate: C: [disclosure of trauma] T: "Oh wow, I've never worked with someone who has had such trauma!" Punishing/Trivializing/Judgmental: T: "Ugh! Why would you tell me that? You know I'm a mandated reporter!," "Well I mean that's bad but it's not the *worst* I've ever heard," or "I've never heard about anything like this happening to anyone but *you*, I wonder what that means" Dismissive: T: "That's not what we're talking about today, we are supposed to talk about your marriage" or changing the topic without being engaged or exploring/commenting further in that session
Unsupportive Responses (NEG2)	Includes responses in which the person exhibits disbelief over the traumatic event,	Disbelief: T: "Did that really happen to you?" "That seems

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	belittles the client, or reacts with outrage or horror at the survivor, offender, or non-protective social supports of the survivor	impossible" or " are you sure it happened the way you're remembering it?" Belittling the client: "You could have been such a better person if this didn't happen to you" or "You may never get over this" Outrage/horror at survivor: T: Therapist gasps aloud in reaction to traumatic disclosure Outrage/horror at offender: T: "I am so angry with the person who did that to you!" Outrage/horror at non-protective social supports: "How could your parents let this happen!? Clearly they are unfit parents!"
Umempathetic Responses (NEG3)	Instances in which the listener is either distracted while the client is speaking; or may be demanding of, or push expectations on, the survivor	Distracted: T: "What were you saying? I'm having a hard time paying attention" Demanding of survivor: T: "I know you said you're not ready to talk about it yet, but we're going to focus today's session on [material related to the traumatic event]," "It's about time you notify your family about this event," "You should really do X,Y, or Z to move on,"or "You really need to face the perpetrator of this right away"

Neutral Responses (Codes NEU1, NEU2)

Codes	Description	Example
Clarifying Questions (NEU1)	Instances of the therapist-participant asking questions (not statements as in POS1 Validation) to gather information or facts regarding the content of the traumatic event or about the client's affective experience.	T: "So what happened after the bomb went off?" "Were you injured badly?" "Who was the one who heard the gun shot?" "What were you feeling when that happened?"
Reflection/Summaries (NEU2)	Includes the therapist participant using "simple" reflective or summary statements that directly and concretely repeat back the content or affective experiences of the events that occurred in the client's recollection of the traumatic event or experience by either simply repeating one or more aspects of what is said, or changing one or more of the words used in a statement, but without adding any new meaning. The client's language is [often/always] used by the therapist when making these types of statements; not questions. Therapist stops at the reflection and does not delve further into suggested meanings of the statements to convey understanding/acceptance of the client's thoughts/feelings/behaviors as in POS1.	Simple Reflection: C: And I now become startled whenever I hear a loud noise. T: Hearing loud noises is startling/frightening for you.

Summary: T: "So when you were in Afghanistan, you experienced XYZ within two months of arrival" "It seems like what you are saying is that first you saw the bomb go off, and after that you ran for cover, trying to survive…" |

Appendix B

Client Information Adult Form

ID # _____

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

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PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

NAME: _____

ADDRESS: _____

TELEPHONE: _____

RELATIONSHIP TO YOU: _____

Medical History

CURRENT PHYSICIAN: _____

ADDRESS: _____

CURRENT MEDICAL PROBLEMS: _____

_____

MEDICATIONS BEING TAKEN: _____

_____

PREVIOUS HOSPITALIZATIONS (MEDICAL OR PSYCHIATRIC)

DATE

_____

_____

_____

OTHER SERIOUS ILLNESSES

DATE

_____

_____

_____

_____

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

DATE

_____

_____

_____

Educational and Occupational History

HIGHEST LEVEL OF EDUCATION ATTAINED:

☐ ELEMENTARY/MIDDLE SCHOOL: LIST GRADE_____   ☐ VOCATIONAL TRAINING: LIST TRADE_____

☐ HIGH SCHOOL: LIST GRADE_____   ☐ COLLEGE: LIST YEARS_____

☐ GED   ☐ GRADUATE EDUCATION: LIST YEARS OR DEGREE EARNED_____

☐ HS DIPLOMA

☐ CURRENTLY IN SCHOOL? SCHOOL/LOCATION:

_____

CURRENT AND PREVIOUS JOBS:

JOB TITLE   EMPLOYER NAME & CITY   DATES/DURATION

_____

_____

HOUSEHOLD INCOME:

☐   UNDER $10,000

☐ $11,000-30,000   OCCUPATION:_____

☐ $31,000-50,000

☐ $51,000-75,000

☐   OVER $75,000

Family Data

IS FATHER LIVING?

YES ☐   IF YES, CURRENT AGE: _____

RESIDENCE (CITY):   _____   OCCUPATION: _____

HOW OFTEN DO YOU HAVE CONTACT?   _____

NO ☐

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

CAUSE OF DEATH: _____

IS MOTHER LIVING?

YES ☐   IF YES, CURRENT AGE: _____

RESIDENCE (CITY):   _____   OCCUPATION: _____

HOW OFTEN DO YOU HAVE CONTACT?   _____

NO ☐

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

CAUSE OF DEATH: _____

BROTHERS AND SISTERS

NAME   AGE   OCCUPATION   RESIDENCE   CONTACT HOW OFTEN?

_____

_____

_____

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

NAME   RELATIONSHIP TO YOU   STILL IN CONTACT?

_____

_____

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

	SELF			FAMILY			
WHICH OF THE FOLLOWINIG HAVE FAMILY MEMBERS, _INCLUDING YOURSELF_, STRUGGLED WITH:	NO- NEVER HAPPENED	UNSURE	YES- THIS HAPPENED	NO- NEVER HAPPENED	UNSURE	YES- THIS HAPPENED	PLEASE INDICATE WHICH FAMILY MEMBER(S)
SEPARATION/DIVORCE	☐	☐	☐	☐	☐	☐	
FREQUENT RE-LOCATION	☐	☐	☐	☐	☐	☐	
EXTENDED UNEMPLOYMENT	☐	☐	☐	☐	☐	☐	
ADOPTION	☐	☐	☐	☐	☐	☐	
FOSTER CARE	☐	☐	☐	☐	☐	☐	
MISCARRIAGE OR FERTILITY DIFFICULTIES	☐	☐	☐	☐	☐	☐	
FINANCIAL STRAIN OR INSTABILITY	☐	☐	☐	☐	☐	☐	
INADEQUATE ACCESS TO HEALTHCARE OR OTHER SERVICES	☐	☐	☐	☐	☐	☐	
DISCRIMINATION (INSULTS, HATE CRIMES, ETC.)	☐	☐	☐	☐	☐	☐	
DEATH AND LOSS	☐	☐	☐	☐	☐	☐	
ALCOHOL USE OR ABUSE	☐	☐	☐	☐	☐	☐	
DRUG USE OR ABUSE	☐	☐	☐	☐	☐	☐	
ADDICTIONS	☐	☐	☐	☐	☐	☐	
SEXUAL ABUSE	☐	☐	☐	☐	☐	☐	
PHYSICAL ABUSE	☐	☐	☐	☐	☐	☐	
EMOTIONAL ABUSE	☐	☐	☐	☐	☐	☐	
RAPE/SEXUAL ASSAULT	☐	☐	☐	☐	☐	☐	
HOSPITALIZATION FOR MEDICAL PROBLEMS	☐	☐	☐	☐	☐	☐	
HOSPITALIZATION FOR EMOTIONAL/PSYCHIATRIC PROBLEMS	☐	☐	☐	☐	☐	☐	
DIAGNOSED OR SUSPECTED MENTAL ILLNESS	☐	☐	☐	☐	☐	☐	
SUICIDAL THOUGHTS OR ATTEMPTS	☐	☐	☐	☐	☐	☐	
SELF HARM (CUTTING, BURNING)	☐	☐	☐	☐	☐	☐	
DEBILITATING ILLNESS, INJURY, OR DISABILITY	☐	☐	☐	☐	☐	☐	
PROBLEMS WITH LEARNING	☐	☐	☐	☐	☐	☐	
ACADEMIC PROBLEMS (DROP-OUT, TRUANCY)	☐	☐	☐	☐	☐	☐	
FREQUENT FIGHTS AND ARGUMENTS	☐	☐	☐	☐	☐	☐	

INVOLVEMENT IN LEGAL SYSTEM	☐ ☐ ☐	☐ ☐ ☐	_____
CRIMINAL ACTIVITY	☐ ☐ ☐	☐ ☐ ☐	_____
INCARCERATION	☐ ☐ ☐	☐ ☐ ☐	_____

Current Difficulties

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

☐ FEELING NERVOUS OR ANXIOUS

☐ UNDER PRESSURE & FEELING STRESSED

☐ NEEDING TO LEARN TO RELAX

☐ AFRAID OF BEING ON YOUR OWN

☐ FEELING ANGRY MUCH OF THE TIME

☐ DIFFICULTY EXPRESSING EMOTIONS

☐ FEELING INFERIOR TO OTHERS

☐ LACKING SELF CONFIDENCE

☐ FEELING DOWN OR UNHAPPY

☐ FEELING LONELY

☐ EXPERIENCING GUILTY FEELINGS

☐ FEELING DOWN ON YOURSELF

☐ THOUGHTS OF TAKING OWN LIFE

☐ CONCERNS ABOUT EMOTIONAL STABILITY

☐ FEELING CUT-OFF FROM YOUR EMOTIONS

☐ WONDERING "WHO AM I?"

☐ HAVING DIFFICULTY BEING HONEST/OPEN

☐ DIFFICULTY MAKING DECISIONS

☐ FEELING CONFUSED MUCH OF THE TIME

☐ DIFFICULTY CONTROLLING YOUR THOUGHTS

☐ BEING SUSPICIOUS OF OTHERS

☐ GETTING INTO TROUBLE

☐ DIFFICULTY WITH SCHOOL OR WORK

☐ CONCERNS ABOUT FINANCES

☐ TROUBLE COMMUNICATING SOMETIMES

☐ CONCERNS WITH WEIGHT OR BODY IMAGE

☐ FEELING PRESSURED BY OTHERS

☐ FEELING CONTROLLED/MANIPULATED

☐ PRE-MARITAL COUNSELING

☐ MARITAL PROBLEMS

☐ FAMILY DIFFICULTIES

☐ DIFFICULTIES WITH CHILDREN

☐ DIFFICULTY MAKING OR KEEPING FRIENDS

☐ BREAK-UP OF RELATIONSHIP

☐ DIFFICULTIES IN SEXUAL RELATIONSHIPS

☐ FEELING GUILTY ABOUT SEXUAL ACTIVITY

☐ FEELING CONFLICTED ABOUT ATTRACTION TO MEMBERS OF SAME SEX

☐ FEELINGS RELATED TO HAVING BEEN ABUSED OR ASSAULTED

☐ CONCERNS ABOUT PHYSICAL HEALTH

☐ DIFFICULTIES WITH WEIGHT CONTROL

☐ USE/ABUSE OF ALCOHOL OR DRUGS

☐ PROBLEMS ASSOCIATED WITH SEXUAL ORIENTATION

☐ CONCERNS ABOUT HEARING VOICES OR SEEING THINGS

ADDITIONAL CONCERNS (IF NOT COVERED ABOVE):

_____

Social/Cultural (Optional)

1. RELIGION/SPIRITUALITY: _____

2. ETHNICITY OR RACE: _____

3. DISABILITY STATUS? _____

APPENDIX C

Telephone Intake Form

ID#_____

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

Pepperdine Community Counseling Center
Telephone Intake Interview

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

"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"

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

☐ Therapy	☐ Child	☐ Individual
☐ Assessment	☐ Adolescent	☐ Couple (Ask if there has been any domestic violence)
☐ Don't know or unsure	☐ Adult	☐ Family
	☐ Don't know or unsure	☐ Group
		☐ Don't know or unsure

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

_____

Reason for Referral

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

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

   FOR WHAT REASON?_____

      CLIENT TOLD LIMITS REGARDING COURT ORDERS? ☐ Y ☐ N

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

_____

ANY CURRENT THOUGHTS OF HURTING YOURSELF?: ☐ Y ☐ N _____

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

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

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

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

  IF SO, PLEASE PROVIDE EXAMPLES:_____

ANY PAST VIOLENCE TOWARDS OTHERS?: ☐ Y ☐ N _____

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

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

_____

_____

_____

_____

_____

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

    IF SO, LIST:_____

DO YOU HAVE ANY SCHEDULE CONSTRAINTS OR TIME/DAY

      REQUESTS?_____

_____

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

WHO IS THE CHILD'S PRIMARY CAREGIVER?: _____

WHO HAS LEGAL CUSTODY OF THE CHILD?: _____

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

    IS THERE DOCUMENTATION AVAILABLE (IN CUSTODY PAPERS ABOUT WHO IS RESPONSIBLE FOR HEALTH CARE) THAT YOU CAN

    BRING TO THE INTAKE SESSION? ❏ Y ❏ N

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

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

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

IS YOUR CHILD COMING VOLUNTARILY/WILLINGLY? ❏ Y ❏ N

Occupation and Fees

ARE YOU CURRENTLY WORKING OR GOING TO SCHOOL? ❏ Y ❏ N

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

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

        WHAT IS (CLIENT'S) OCCUPATION?:_____

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

Intake Interviewer Checklist

▨ I INFORMED THE POTENTIAL CLIENT OF LIMITS OF CONFIDENTIALITY FOR THE PHONE INTERVIEW

☐ I INFORMED THE POTENTIAL CLIENT OF THE NONREFUNDABLE $25.00 INTAKE SESSION FEE.

☐ I INFORMED THE POTENTIAL CLIENT THAT CLINIC THERAPISTS ARE UNLICENSED GRADUATE STUDENTS WHO ARE SUPERVISED BY LICENSED PROFESSIONALS (CLINICAL PSYCHOLOGISTS AND/OR MARRIAGE FAMILY THERAPISTS)

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☐ I INFORMED THE POTENTIAL CLIENT THAT AS PART OF THEIR TRAINING, THERAPISTS ARE ASKED TO PRESENT VIDEO (AND SOMETIMES AUDIO) TAPED SAMPLES OF THEIR SESSIONS DURING SUPERVISION.

☐ (PER CLINIC POLICY) I ASKED THE POTENTIAL CLIENT FOR PERMISSION TO HAVE THE INTAKE THERAPIST GIVE THEM A CALL PRIOR TO THE INTAKE SESSION

☐ I INFORMED THE POTENTIAL CLIENT THAT THE INTAKE SESSION IS 2.5 HOURS IN LENGTH AND THAT THIS SESSION HELPS THE THERAPIST AND HIS/HER SUPERVISOR GAIN A BETTER UNDERSTANDING OF THE POTENTIAL CLIENT'S PRESENTING PROBLEMS. GATHERING THE INFORMATION DURING THIS FIRST SESSION IS CRUCIAL FOR TREATMENT PLANNING. I ALSO INFORMED THE POTENTIAL CLIENT OF THE IMPORTANCE OF ARRIVING PROMPTLY FOR THE SESSION.

☐ I INFORMED THE POTENTIAL CLIENT THAT FOLLOWING THE INTAKE SESSION, THE THERAPIST WILL PROVIDE HIM/HER WITH FEEDBACK AND MAKE TREATMENT RECOMMENDATIONS WHICH MAY BE FOR CONTINUED TREATMENT IN OUR CLINIC OR MAY BE A REFERRAL TO ANOTHER CLINIC.

☐ I INFORMED THE CLIENT THAT THEIR PLACEMENT WITH A THERAPIST IS SOMEWHAT DEPENDENT ON THE POTENTIAL CLIENT'S TIME FLEXIBILITY.

☐ (PER CLINIC POLICY) I CREATED A CLIENT FILE AND PLACED THE TELEPHONE INTAKE INTERVIEW IN IT.

☐ (PER CLINIC POLICY) I PROVIDED THE CLINIC DIRECTOR WITH THE TELEPHONE INTAKE INTERVIEW.

☐ (PER CLINIC POLICY) I ASSIGNED THE POTENTIAL CLIENT TO A THERAPIST.
THERAPIST:_____

☐ I INFORMED THE POTENTIAL CLIENT ABOUT THE CLINIC LOCATION AND PARKING ARRANGEMENTS.

☐ I CONTACTED THE RFERRAL SOURCE AND THANKED THEM.

☐ (PER CLINIC POLICY) I SCHEDULED THE INTAKE SESSION.
DATE:_____
TIME:_____
THERAPIST:_____

sample

APPENDIX D

Intake Evaluation Summary

Pepperdine Psychological and Educational Clinic

Client: _____ Intake Therapist: _____

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

I   Identifying Information

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

II   Presenting Problem/Current Condition

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

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

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

IV   Psychosocial History

        A   Family History

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

B   Developmental History

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

C   Educational/Vocational History

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

D   Social Support/Relationships

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

E   Medical History

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

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

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

G   Legal History

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

V   Mental Status Evaluation

Hygiene & grooming:

   Interpersonal presentation/behavioral observations:

Orientation (person, place, time, situation):

   Speech (pitch, pace, tone):

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

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

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

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

   Thought Content (appropriate; delusions; odd ideations):

   Perceptual Disturbances (hallucinations):

   Cognitive Functioning (intellectual functioning, fund of knowledge):

   Concentration, Attention & Memory:

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

VI   Client Strengths

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

VII   Summary and Conceptualization

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

VIII   DSM-IV TR Multiaxial Diagnosis

Axis I:

Axis II:

Axis III:

Axis IV:

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

Current GAF:

Highest GAF during the past year:

IX   Client Goals

X   Treatment Recommendations

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

_____   _____

Intake Therapist   Supervisor

_____

Date

TREATMENT SUMMARY

Identifying Information:

_____

_____

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Revised 4-15-2009

Diagnosis at Termination:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

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

_____
_____
_____
_____
_____
_____
_____

Recommendations for Follow-Up (*If the case 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 F

Participant Selection Tracking Sheet (SAMPLE)

Research ID	Total # of Sessions	Experience of Trauma (Ct Info- Adult Form; Intake; Tx Summary; Phone Intake)	Death/Loss; SA; PA; Rape/Sexual Assault; Illness/Injury/Disability; Culturally-based trauma	Trauma Discussion Session #	Other Demographic Factors

APPENDIX G

Client Consent Form

Pepperdine University
Counseling and Educational Clinics
Consent for Services

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

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:

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

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

Consent to Video/audiotaping and Observations: It is standard procedure at our clinic for sessions to be audiotaped and videotaped for training/teaching and/or research purposes. **It should be noted that videotaping for teaching/training**

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purposes is a prerequisite for receiving services at our clinic. In addition, sessions may be observed by other therapists and/or supervisors at the clinic through the use of a one-way mirror or direct in-session observation.

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

_____   Video/audiotaping

_____   Direct Observation

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

Please choose from the following options (confirm your choice by initialing in the margin).
- I understand and agree that information from my services
will be included in the Research Database (check all that apply).

_____   Written Data

_____   Videotaped Data

_____   Audiotaped Data

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

- I understand and agree that I may be contacted in the future
    about the opportunity to participate in other specific research
programs.   _____
OR
- I do not wish to be contacted in the future

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about the opportunity to participate in other specific research programs.

_____

Fees: The fee for the initial intake is nonrefundable.

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

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

_____

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

_____

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

•   Your therapist may consult with other mental health professionals regarding your case. The consultants are usually affiliated with Pepperdine University. Your therapist may also discuss your case in other teaching activities at Pepperdine, such as class discussions, presentations and exams. Every effort is made to avoid revealing your identity during such teaching activities.

•   If the situation involves a serious threat of physical violence against an identifiable victim, your therapist must take protective action, including notifying the potential victim and contacting the police.

- If your therapist suspects the situation presents a substantial risk of physical harm to yourself, others, or property he/she may be obligated to seek hospitalization for you or to contact family members or others who can help.
- If your therapist suspects that a child under the age of 18, an elder, or a dependent adult has been a victim of abuse or neglect, the law requires that he/she file a report with the appropriate protective and/or law enforcement agency.
- If you are involved in a court proceeding and a request is made for information about the services provided to you, the clinic cannot provide any information, including release of your clinical records, without your written authorization, a court order, or a subpoena.
- If you file a complaint or lawsuit against your therapist and/or the clinic, disclosure of relevant information may be necessary as part of a defense strategy.
- If a government agency is requesting the information pursuant to their legal authority (e.g., for health oversight activities), the clinic may be required to provide it for them.
- If the clinic has formal business associates who have signed a contract in which they promise to maintain the confidentiality of your information except as specifically allowed in the contract or otherwise required by law.

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

_____

Your Records: The clinic keeps your Protected Health Information in your clinical records. You may examine and/or receive a copy of your records, if you request it in writing, except when: (1) the disclosure would physically or psychologically endanger you and/or others who may or may not be referenced in the records, and/or (2) the disclosure includes confidential information supplied to the clinic by others.
HIPAA provides you with the following rights with regard to your clinical records:
- You can request to amend your records.
- You can request to restrict from your clinical records the information that we can disclose to others.
- You can request an accounting of authorized and unauthorized disclosures we have made of your clinical records.
- You can request that any complaints you make about our policies and procedures be recorded in your records.
- You have the right to a paper copy of this form, the HIPAA notice form, and the clinic's privacy policies and procedures statement.

The clinic staff is happy to discuss your rights with you.
Treatment & Evaluation of Minors:
As an unemancipated minor (under the age of 18) you can consent to services subject to the involvement of your parents or guardians.

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

_____

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

_____   and/or   _____
Signature of client, 18 or older   Signature of parent or guardian
(Or name of client, if a minor)

                                                                    _____
                                                                    Relationship to client

                                                                    _____
                                                                    Signature of parent or guardian

                                                                    _____
                                                                    Relationship to client

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

_____   _____
Clinic/Counseling Center   Translator
Representative/Witness

_____
Date of signing

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**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 <u>do not</u> wish to have <u>any/all</u> of the above information included in the Research Database.

          _____

<u>Please choose from the following options by placing your initials on the lines.</u>
• _____   I understand and agree that I may be contacted in the future about the opportunity to participate in other specific research programs at the GSEP Clinic or Counseling Center.

          _____
          OR
• _____   I <u>do not</u> wish to be contacted in the future about the opportunity to participate in other specific research programs at the GSEP Clinic or Counseling Center.

     _____

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)

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

UCLA Health System

Certificate of Completion

This is to certify that

Krista Kircanski

_____

has completed the
HIPAA Training
on

Thursday, October 11, 2012

_____

Reference No: 118142

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research
certifies that **Krista Kircanski** successfully completed the NIH Web-
based training course "Protecting Human Research Participants".

Date of completion: 06/10/2011

Certification Number: 700724

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

July 1, 2013

Protocol #: P0513D15
Project Title: Student Therapists' Use of Self-Disclosure With Clients Who Have Experienced Trauma

Dear Ms. Kircanski,

Thank you for submitting your application, *Student Therapists' Use of Self-Disclosure With Clients Who Have Experienced Trauma*, for expedited review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your advisor, Susan Hall, completed on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 (Research Category 5 and 6) of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

I am pleased to inform you that your application for your study was granted **Approval.** The IRB approval begins today, **July 1, 2013,** and terminates on **June 30, 2014**. In addition, your application to waive documentation of informed consent, as indicated in your **Application for Waiver or Alteration of Informed Consent Procedures** form has been **approved.**

Please note that your research must be conducted according to the proposal that was submitted to the GPS IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For *any* proposed changes in your research protocol, please submit a Request for Modification form to the GPS IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and require submission of a new IRB application or other materials to the GPS IRB. If contact with subjects will extend beyond **June 30, 2014**, a **Continuation or Completion of Review Form** must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to "policy material" at http://www.pepperdine.edu/irb/graduate/).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact me. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,

Doug Leigh, Ph.D.

Chair, Graduate and Professional Schools IRB
Pepperdine University

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
        Ms. Alexandra Roosa, Director Research and Sponsored Programs
        Dr. Susan Hall, Graduate School of Education and Psychology