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Pepperdine University
Graduate School of Education and Psychology

TRAINEE THERAPIST RESPONSES TO THE DISCUSSION OF TRAUMA IN
THERAPY

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

by

Courtney Bancroft

October, 2014

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

This clinical dissertation, written by

Courtney Bancroft

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

John Briere, Ph.D.

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ACKNOWLEDGEMENTS

As I sit and reflect on this amazing process, I am overwhelmed with happiness, relief, pride, and joy. It is impossible not to think of all the wonderful souls who helped me, in so many ways, to complete this dissertation and ultimately my doctorate. I am overwhelmed and forever grateful for all of the support from the most wonderful family, friends, mentors, and boyfriend. Thank you, from the bottom of my heart. Thank you to the most phenomenal chairperson, Dr. Susan Hall, for your guidance, your wisdom, and most of all your patience and extreme dedication throughout this process. Thank you to my mentors and chairpersons, Dr. John Briere and Dr. Edward Shafranske, who have supported me, pushed me, and been true inspirations, not only during the dissertation process, but also throughout my graduate school experience. I am also absolutely 100% convinced that I would not have been able to complete this process without my witty, wonderful, and always available team, Krista Kircanski and Roxana Zarabbi, and the other members of the PARC legacy, without whom we would have been lost. Thank you to the APA reviewers, to the editors, to the wonderful group of friends, colleagues, peers, and mentors at Pepperdine and Yale, who helped push me, keep me on track, and be my biggest cheerleaders. And to my family, the most giving, loving, generous, supportive, and fantastic group of humans alive- words cannot express how much your supportive words, your pride and faith in me, and your many other means of support have helped me over the last four years. This would not have been possible without you. Finally, I must thank the love of my life, the truest and most unwavering support I could ever dream of, who I met in the midst of this madness... it is finally over. Thank you for your help, your love, your cooking, your patience, understanding, and encouragement. We did it.

VITA

COURTNEY F. BANCROFT

Education

PEPPERDINE UNIVERSITY

LOS ANGELES, CA

Doctor of Psychology Degree in Clinical Psychology, Psy.D.

05/2014

- Accredited by the American Psychological Association
- Dissertation: Trainee Therapist Responses to the Discussion of Trauma in Therapy
Chairperson: Dr. Susan Hall *Committee Members:* Dr. John Briere and Dr. Edward Shafranske

LOYOLA COLLEGE IN MARYLAND

BALTIMORE, MD

Master of Science Degree in Clinical Psychology, M.S.

09/2009

- Accelerated BA/MS Clinical Thesis-Track Program 2007-2009
- Masters Thesis: Bancroft, C. (2009). Heterosocial Competence as Related to Quality and Aggression in College Student Romantic Relationships. *Chairperson:* Dr. Rachel Grover

LOYOLA COLLEGE IN MARYLAND

BALTIMORE, MD

Bachelor of Arts Degree in Psychology with Art History minor, B.A.

05/2008

Clinical Experience

YALE SCHOOL OF MEDICINE

NEW HAVEN, CT

APA Accredited Predoctoral Fellowship

07/2013-06/2014

- Achieved professional competency in providing psychological services and furthered leadership skills through intensive 50 hour per week supervised experience
- Presented case material in twice-weekly case conferences to master competency of clinical skills, team communication, and case conceptualization and presentation
- Received 7 hours per week of supervision from a range of licensed clinicians to further core competencies of assessment, intervention/prevention, consultation, scholarly inquiry/research, professional development, evaluation, systems based practice
- Participated in 4 hours per week of research via Scholarly Project entitled: A Crisis of Insight: Therapist insight as best practice
- Attended weekly seminars and didactic trainings covering a wide range of topics

PRIMARY PLACEMENT RESPONSIBILITIES: SUBSTANCE ABUSE TREATMENT UNIT

Supervisors: Donna LaPaglia, PsyD, Matt Steinfeld, PhD, Brian Kiluk, PhD, John Cline, PhD

- Functioned within large outpatient team to provide services to racially, ethnically, economically, and psychologically diverse populations from the Greater New Haven area
- Conducted rapid clinical assessment and evaluation of clients presenting for services; maintained a caseload of 15-20 cases; provided evidence-based practices in individual and group settings

- Participated in Divisions of Addictions Research via didactics and clinical research
- SECONDARY PLACEMENT RESPONSIBILITIES: ADULT OUTPATIENT SERVICES (AOS)**
Supervisors: Allison Ponce PhD, Madelon Baronoski, PhD, Nancy Watsky, APRN
- Provided individual and group psychotherapy to adults on interdisciplinary teams
 - Collaborated with patients and supervisors to include recovery model and person-centered treatments with adults with serious mental illness and to help empower clients in a range of opportunities beyond clinical care
 - Conducted psychological tests as needed to maintain competencies in assessment skills

VA LONG BEACH HEALTHCARE SYSTEM

LONG BEACH, CA

Supervisors: Vanessa Zizak, Ph.D., Duke Han, Ph.D.

11/2012-06/2013

Neuropsychology Assessment Clerk Volunteer

- Conducted intake and diagnostic interviews prior to assessment administration for the purpose of gathering background information, presenting problem, and diagnostic timeline
- Administered, scored, and interpreted neuropsychological assessment batteries with adults and older adults in the VA healthcare system
- Produced comprehensive reports for differential diagnosis and recommendations
- Received weekly supervision and didactic training regarding neuropsychological assessment

HARBOR UCLA-DUAL DIAGNOSIS TREATMENT PROGRAM

TORRANCE, CA

Supervisors: Lee Gomberg, Ph.D., John Tsuang, M.D.

09/2012-06/2013

Psychology Extern/Clinician

- Provided weekly, individual Cognitive-Behavior Therapy (CBT) psychotherapy for clients in the Dual Diagnosis Treatment Program (DDTP) at Harbor UCLA Medical Center serving a diverse group of patients suffering from both psychiatric and substance use disorders (SUDs)
- Conducted rapid intake evaluations and assessments for new applicants to the DDTP outpatient program involving in-depth clinical interviews
- Led and co-facilitated several groups dealing with stress, substance use, dual-diagnosis, relationships, coping and maintenance of sobriety, healthy habits, and health awareness
- Conducted presentations on therapy topics and techniques to multidisciplinary team
- Participated in hospital-wide didactic seminars and training programs on a weekly basis
- Attended rotations to the Psych ER twice per month to enhance crisis intervention skills
- Weekly participation in supervision to enhance skills and review ethical procedures including the review of video-taped sessions with individual clients

LAC+USC MEDICAL CENTER-AUGUSTUS HAWKINS

LOS ANGELES, CA

Supervisors: Elaine Eaton, Ph.D., Lucy Erickson, Ed.D.

09/2011-11/2012

Adult Inpatient Assessment Clerk/Therapist

- Provided assessment and treatment services to adults with acute and severe psychiatric disorders, often complicated by substance abuse and/or medical conditions
- Conducted both weekly inpatient process group therapy group and DBT skills group with clients from diverse cultural and ethnic backgrounds, and of various levels of functioning

- Administered psychological assessments to adult psychiatric inpatients including complete diagnostic interviewing, administration, scoring, and interpretation of psychological tests, integration of test results, DSM-IV-TR diagnostic formulation, preparation of integrated written report summarizing findings and recommendations
- Presented psychological assessment results to supervisors, patients, the referring psychiatric resident or attending, and at interdisciplinary team rounds, family meetings, and case conferences
- Participated in multidisciplinary didactic seminars regarding adult inpatient psychiatric service specialty topics, and received ongoing supervision to enhance professional development

WEST LA PEPPERDINE COMMUNITY COUNSELING CLINIC
Supervisors: Aaron Aviera, Ph.D., Edward Shafranske, Ph.D.

LOS ANGELES, CA
 05/ 2011-06/2013

Clinician/Therapist

- Provided CBT and dynamic treatments to a diverse group of outpatient adult clients
- Conducted intake interviews with clients from diverse cultural and socioeconomic backgrounds
- Coordinated treatment planning and helped to guide individual weekly therapy sessions with such clients to address presenting issues (e.g., personality disorders, mood and anxiety disorders)
- Participated in weekly supervision group to improve therapeutic techniques, maintain ethics and review video recorded sessions among colleagues and supervisor

WISEBURN SCHOOL DISTRICT
Supervisor: Sepida Sazgar, Psy.D.

HAWTHORNE, CA
 11/2011 - 06/2012

Child Therapist

- Conducted a variety of services for grades Kindergarten through 6th grade, including one-on-one and group interventions, classroom presentations, family counseling, education and skill training
- Worked with school psychologist and principals to coordinate care and counseling for children struggling with issues in the home environment, divorce or parental separation, grief and loss, family members with mental illness, and/or behavioral problems in the home or school
- Incorporated play therapy, skill training, family therapy and psychoeducation to children and families in order to enhance interpersonal, family, and academic interactions
- Triaged and assessed crisis issues pertaining to child physical and sexual abuse
- Participated in both supervision and peer-supervision on a weekly basis to enhance child counseling skills and review ethical procedures and guidelines

UNION RESCUE MISSION-CONRAD HILTON FOUNDATION
Supervisors: Aaron Aviera, Ph.D., Stephen Strack Ph.D.

LOS ANGELES, CA
 09/2010 - 08/2011

Clinician/Fellow

- Conducted individual weekly therapy with clients from diverse cultural and ethnic backgrounds including homeless community within Union Rescue Mission, a residential treatment facility, to address presenting issues such as substance abuse, mood disorders, and relationship concerns

- Incorporated CBT and psychodynamic theory, and cognitive and emotional assessments to foster ongoing treatment planning for the chronic and persistent mentally ill
- Co-led Diabetes support group in conjunction with UCLA medical students to provide information, support, and therapeutic interventions for clients with Diabetes
- Provided psychoeducation to URM security staff in order to enhance awareness and recognition of mental illness, thereby improving client safety
- Participated in weekly group and individual supervision to enhance skill development

BALTIMORE CRISIS RESPONSE INC.

BALTIMORE, MD

Supervisor: Linda Fauntleroy

07/2008 - 06/2009

Employed as Crisis Intervention Counselor

- Triaged callers' presenting problems, including lethality assessment, support systems, coping skills and level of emergency to determine appropriate intervention for crisis calls
- Utilized counseling skills, active listening, and empathy to establish rapport and intervene appropriately with callers who presented imminent danger to self or others
- Actively participated in organization's professional development program, including: regular supervision, clinical training seminars, and professional development seminars

Leadership Experience

LAC+USC MEDICAL CENTER-AUGUSTUS HAWKINS: INPATIENT

LOS ANGELES, CA

Supervisors: Lucy Erickson Ed.D., Elaine Eaton, Ph.D.

09/2012 – 06/2013

Assessment Peer-Supervisor

- Provided training, mentorship, and guidance to psychology students serving as psychology assessment clerks on inpatient units and reported progress to supervisors
- Co-facilitated inpatient group psychotherapy sessions and demonstrated and reviewed techniques, progress note writing, and post-group processing
- Served as a model for the shadowing of interview skills and assessment administration
- Assisted with and review scoring, interpretation and report writing for psychodiagnostic and cognitive assessments and create inventory of current assessments for program

PEPPERDINE UNIVERSITY: UNION RESCUE MISSION PRACTICUM

LOS ANGELES, CA

Supervisor: Aaron Aviera, Ph.D.

09/2012 -06/2013

Clinical Peer-Supervisor

- Provided support, assisted with case-management, and served as a guide for the enhancement of students' training needs while reporting progress to main supervisors
- Met face-to-face on a weekly basis for one hour to discuss case-management including session material, therapeutic relationships, transference and countertransference as well as review video/audio tapes of clinical material
- Provided immediate feedback and consultation regarding clinical crisis issues
- Reviewed students' charts and intakes to provide feedback, with focus on new clients
- Served as a mentor for students addressing such things as classes, practicum and dissertation
- Attended weekly case conference and supervision regarding the peer supervision of other students

PEPPERDINE UNIVERSITY SGA
Student Government Association

LOS ANGELES, CA
06/2012 – 06/2013

Class Representative

- Served as liaison between class and student government association in order to create cohesion between the psychology program and student body
- Communicated the opinions/concerns of the student body to align program with needs
- Created programs and events to increase self-care and philanthropy among students
- Attended monthly meetings and reported meeting conclusions to classmates

LOYOLA UNIVERSITY MARYLAND
PSI CHI: International Honors Society in Psychology

BALTIMORE, MD
05/2007 - 05/2008

President

- Maintained regulations and traditions associated with the PSI CHI society for the Loyola University Chapter in order to uphold standards of the international society
- Reviewed applicant requirements as based on both the international standard as well as Loyola University standards in order to choose new students for honors society induction
- Held monthly meetings with other cabinet members in order to foster communication
- Planned annual induction ceremony event and lead induction process for new members

Assessment Training

Doctoral and Masters Level

07/2008 -PRESENT

Test administration, scoring, interpretation, and report writing with children, adults, and older adults

Cognitive and Neuropsychological Assessments

WAIS-IV, WASI, WMS-IV, Cognistat, RBANS, MMSE, MMS-3, COWAT, RAVLT, WRAT-4, Trailmaking Test, Color Trails, Bender Visual-Motor Gestalt-II, Beery-VMI-5, BNT, Boston Cookie Theft, MOCA, DKEFS, RAVLT, COWAT, Wisconsin Card Sorting Test

Emotional Assessments

Rorschach, MMPI-2, MMPI-2RF, MCMI-III, PAI, TAT, HTP, RISB, BSI

Malingering Assessments

the b test, the Rey 15-item Malingering Test

Teaching Experience

PEPPERDINE UNIVERSITY-GSEP

MALIBU, CA

Teaching Assistant

01/2013-06/2013

For Susan Hall, Ph.D., & Kathleen Eldridge, Ph.D.

- Chosen to be a Teaching Assistant (TA) for Theories and Techniques of Cognitive Behavioral Therapy Masters level course, focusing on 1st, 2nd, and 3rd wave CBT approaches, including mindfulness and acceptance based approaches and gave input about course design
- Provided guidance and assistance in skill development by reviewing videotapes of student role plays/practice intakes, and sessions; by leading workshops and activities; and by teaching course as guest lecturer on occasion throughout the semester

PEPPERDINE UNIVERSITY-GSEP

LOS ANGELES, CA

Teaching Assistant

09/2011-06/2013

For Carolyn Keatinge, Ph.D., Susan Himelstein, Ph.D., & Sepida Sazgar, Psy.D

- Teaching Assistant for Cognitive, Emotional, and Advanced Assessment courses
- Chosen to personally instruct class members who missed classes on an individual basis
- Provided guidance and assistance in skill development for cognitive and emotional assessments
- Administered testing lab for WISC-IV, WAIS-IV, and Rorschach and reviewed accuracy of student's scoring, provided feedback to be reviewed by instructor, and gave exam feedback

KINGSBOROUGH COMMUNITY COLLEGE

BROOKLYN, NY

Adjunct Faculty Lecturer

09/2009 – 06/2010

Department Chair: William Burger, Ph.D.

- Instructed five General Psychology courses as part of curriculum's social science requirement
- Developed course focusing on foundational topics, including: historical background, scientific methodology, biological substrates, principles of learning and memory, key developmental perspectives/theories, and current perspectives on abnormal behavior and psychological disorder
- Administered exams and evaluated papers to assess students' competencies
- Answered in-class queries and held office hours for further assistance and information

LOYOLA UNIVERSITY MARYLAND

BALTIMORE, MD

Teaching Assistant

09/2008 - 12/2008

For Elizabeth MacDougall, Ph.D.

- Instructed lab portion of course, Psychodiagnostics I: Introduction to Cognitive Assessment
- Provided guidance towards skill development, specifically in areas of administration, scoring, and interpreting the WAIS-III, WISC-IV, WIAT-II, & Beery VMI-5
- Offered guidance and assistance on how to conduct assessments and write reports

RESEARCH EXPERIENCE

PEPPERDINE UNIVERSITY-PEPPERDINE APPLIED RESEARCH CENTER LOS ANGELES, CA

Supervisor/Primary Investigator: Susan Hall, J.D., Ph.D.

06/2011 – 06/2013

- Supervised masters level research assistants in the Positive Psychology Dissertation lab at both the West Los Angeles and Irvine clinic locations as they entered therapist/client information into clinic database and participated in RA meetings and quality control
- Developed and maintained research infrastructure at West Los Angeles and Irvine clinics
- Gathered data on specific clinical issues and decisions facing graduate student therapists, their supervisors and clients, in order to address gaps in the current research base
- Created de-identified files for clinic database and readied the database for research assistant review

GETTING OUT BY GOING IN- GOGI*Coach Mara Leigh Taylor*

LOS ANGELES, CA

04/2012 – 07/2012

Co-author/Research Coordinator

- Worked as a volunteer for an organization offering tools, support, classes and knowledge to the prison population nationwide
- Coordinated research and information team for a literature review regarding current practices, treatments, and rates of recidivism
- Explored foundational evidence-based techniques that comprise the GOGI tools, and incorporated the information into a book chapter in “How to GOGI II,” for professionals

JOHNS HOPKINS HOSPITAL*Supervisor/Primary Investigator: Marco Grados, M.D.*

BALTIMORE, MD

01/2009 – 05/2009

Research Assistant/Extern

- Collected data on three projects, concerning children with Obsessive Compulsive Disorder (OCD), Tourette Syndrome (TS), and Cornelia de Lange syndrome (CdLS)
- Contacted participants, recruited participants, entered and analyzed data in MS Excel, STATA, and SPSS/PASW, and assisted in grant writing, budget, and receipt reimbursement

LOYOLA UNIVERSITY MARYLAND*Primary Investigator: Kerri Goodwin, Ph.D.*

BALTIMORE, MD

01/2007 – 05/2008

Graduate Research Assistant

- Assisted faculty member on research study entitled “Conformity, Confidence & Eyewitness Memory” and prepared paper for presentation at EPA convention 2008
- Explored effects of conformity and confidence on eyewitness memory by posing as confederate in study and collecting and analyzing data

RANDI KORN & ASSOCIATES, INC.**Data Collector**

ALEXANDRIA, VA

11/2007 – 01/2008

- Collected data at Walters Art Museum to assist with museum evaluation and research
- Covertly evaluated the behavior of 100 random museum visitors to a specific exhibit to measure number of visitors, time spent at each display, and number of technologies used during exhibit

Publications/Papers Presented

Bancroft, C. F., & Winters, B. N. (in press). GOGI from a clinical perspective. In M. L. Taylor & D. Martinez (Eds.). *How to GOGI II: The manual for the facility, educator, and mental health professional* (pp. 469 – 488). Los Angeles, CA: Getting Out By Going In.

Grover, R.L., Perez, M.V., & **Bancroft, C.F.** (2009). Interventions to Improve Heterosocial Competence in Adolescent and Young Adult Clients: A guide for practitioners. *Independent Practitioner, 29*, 144-146.

Goodwin, K.A., Kukucka, J., **Bancroft, C.**, Bukowski, A., Mahfouz, S., Minott, T., Moise, G., & Thorn. (2008). Conformity, confidence, and eyewitness memory. Paper presented at 2008 Meeting of the Eastern Psychological Association, Boston,

MA, March 13-16, 2008.

Professional Certifications

Motivational Interviewing With Substance Using Clients *JUNE 2014*

- Options in Psychotherapy Training: 4 Scientifically Validated Behavioral Treatments (OPT4)

Cognitive behavioral Therapy for Substance Abuse *SEPTEMBER 2013*

- Options in Psychotherapy Training: 4 Scientifically Validated Behavioral Treatments (OPT4)

Acupuncture Detoxification Specialist *JULY 2013*

- National Acupuncture Detoxification Association

Small Group Critical Incident Stress Debriefing *MAY 2009*

- Johns Hopkins University, Trainer: George Everly, PhD

Professional Organizations

PEPPERDINE UNIVERSITY FORENSIC ASSOCIATION 2011-PRESENT

AMERICAN PSYCHOLOGICAL ASSOCIATION STUDENT AFFILIATE 2010-PRESENT

DIVISION 13-SOCIETY OF CONSULTING PSYCHOLOGISTS

DIVISION 50-ADDICTIONS

DIVISION 56-TRAUMA PSYCHOLOGY

PSI CHI, THE INTERNATIONAL HONORS SOCIETY IN PSYCHOLOGY 2006-PRESENT

Honors/Awards

Pepperdine University

- Featured in Pepperdine-Fund Newsletter 2012 for “inspirational work” at URM
- Awarded Fellowship position for Conrad Hilton Foundation 2010-2011
- Pepperdine University Colleagues Grant Recipient 2010-2011

Loyola College

- Awarded the Josephine & Louis Natale Fund Scholarship 2006-2008
- Elected President of PSI CHI 2007-2008
- Awarded the Art History Achievement Award in 2007
- Nominated for 2007 Honor Council
- Selected to present at 2007 Undergraduate Student Research & Scholarship

Colloquium

- Dean’s List Spring & Fall 2005, Spring 2006 & Spring 2007

Skills

- Proficient in SPSS/PASW, STATA, MS Word, PowerPoint, & Excel, Web-based Data Entry, and Survey Creation, with knowledge of Visual Basic and Java Programming Language

ABSTRACT

Responses to disclosures/discussions of trauma can have lasting impacts on survivors who choose to share their experiences and historically have been categorized as positive, negative, and/or neutral responses with corresponding effects on the survivor. Literature recommends the use of tenets and techniques reminiscent of therapeutic common factors (e.g., listening skills, empathy, support, validation, creating a safe environment and strong therapeutic alliance) when responding to trauma. However, existing research focuses on reactions to survivors' disclosures outside of therapy and there is little research focusing on therapists' responses. Specifically, there are no studies that investigate how therapists or trainees are actually responding in psychotherapy sessions (e.g., frequency and rate of such responses).

Accordingly, the purpose of the present study was to qualitatively explore the responses of student therapists 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 trainee therapist-participants discussed trauma were analyzed using a qualitative and deductive content analysis. A coding system was created to categorize responses based on extant literature. Results indicated that trainee therapist-participants responded in all proposed categories (positive: validating, supportive, empathic; negative: invalidating, unsupportive, unempathetic; and neutral: clarifying questions, and reflection/summary statements). Of these, neutral responses tended to occur more frequently than positive or negative responses. Overall, positive responses followed as next most frequent and negative

responses as least frequent. Other findings included that in 2 of the 5 individual sessions, negative responses were more frequent than positive responses; empathic responses were the least frequent code across all 10 coding categories; and 2 sessions had 0 recorded empathic responses. Finally, there were numerous missed opportunities for positive responding throughout the sessions.

It is hoped that this study will raise awareness around the importance of therapeutic responses to trauma survivors' discussions in psychotherapy sessions and provide insight as to how trainee therapists might apply their existing competencies to respond to clients in positive ways. Findings have implications for both future studies and clinical training practices, for example in graduate programs for trainee therapists, an area of study that is currently under-researched.

Chapter I. Literature Review

Research demonstrates that trauma may be detrimental to the individual who has experienced it, and depending on the type, severity, and length of the trauma(s), can lead to short-term, or prolonged consequences for the survivor (Briere & Scott, 2012; Herman, 2009; Hong, Illardi, & Lishner, 2011; Kessler & Goff, 2006). However, research also shows that not all individuals experience lasting negative effects as a result of traumatic experiences (Briere & Scott, 2012). Moreover, from a positive psychology perspective, “struggles with trauma can produce positive outcomes” (Briere & Scott, 2006, p. 67).

One factor that appears to affect the outcome of a traumatic experience(s) is the process of disclosing or discussing the trauma(s) with others. Such discussions can be both difficult and therapeutic for the traumatized individual. Difficulties surrounding discussion may arise for those who view trauma to be an “unknowable and unshareable experience” (Grand, 2000, p. 4), or may present because many individuals feel a “profound sense of singularity” (Stolorow, 1999, p. 465) in regards to the trauma(s) they have experienced. But for those who can tell their story to their therapists or to others close to them, having a narrative as a vehicle through which they can disclose the trauma seems to be of utmost importance for healing, especially in a therapeutic relationship (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011).

As important as the decision to disclose, is the reaction or response with which the disclosure is met (Shenk & Fruzzetti, 2011). There are many types of reactions and responses to trauma disclosure, such as positive responses, negative responses, or neutral/no-response reactions (Linehan, 1993; Shenk & Fruzzetti, 2011). Research demonstrates that disclosing a traumatic event to an invalidating listener may actually

contribute to problematic psychological outcomes and may have serious diagnostic implications. For example, it may contribute to a diagnosis of PTSD, or may increase the level at which the individual experiences the PTSD (Shenk & Fruzzetti, 2011; Ullman, 2007). Although there is extant research regarding positive, negative, and neutral responses to a survivor's traumatic disclosure in general, there is still little information about the specific effects of the therapists' reactions or responses to trauma discussion. Similarly, there is minimal training for therapists regarding how to respond to a client's discussion of trauma. This gap in research and training may lead to unnecessary and unintentional negative consequences for the disclosing survivor. Therefore, the purpose of this study is to explore how trainee therapists respond to their clients' discussions of traumatic events.

The literature review begins with a discussion of positive psychology and its relation to psychotherapy and trauma. Common psychotherapeutic interventions in working with trauma survivors, and the common factors among these interventions are also reviewed. The literature on the disclosure and discussion of trauma is then explained, including definitions and ways of discussing trauma. Research findings regarding the responses and reactions to discussions of trauma are then discussed. Finally, this chapter relates therapists' reactions to trauma discussions and psychotherapeutic interventions. The chapter concludes with a description of the purpose of the study and its research question.

Positive Psychology, Psychotherapy, and Trauma

This section describes the field of positive psychology, its connection to psychotherapy, and critiques of positive psychology. Next, trauma definitions and types

of trauma are discussed. Last, possible positive and negative effects that can impact the survivor are reviewed.

Positive psychology. The field of positive psychology developed in response to the perceived imbalance of a heavy focus on pathology and illness in the field of clinical psychology versus a focus on strengths and positivity (Gable & Haidt, 2005). Positive psychology has built upon existing areas of psychology, such as giftedness, meaning making, and positive human characteristics (e.g., Allport, 1958; Gable & Haidt, 2005; Jung, 1933; Maslow, 1968; Terman, 1939).

Positive psychologists set out to understand human strengths (e.g., optimism, faith, gratitude, positive emotions, humor) that could be fostered to buffer against mental illness, in an effort to understand the full spectrum of human experience (Seligman & Csikszentmihalyi, 2000). As further described below in a subsection on trauma, positive psychology recognizes the ability of people to flourish rather than enduring and surviving difficult experiences (Gable & Haidt, 2005). Seligman and Csikszentmihalyi (2000) asserted that “the aim of positive psychology is to begin to catalyze a change in the focus of psychology from preoccupation only with repairing the worst things in life to also building positive qualities” (p. 5). Seligman (2002) declared the three pillars of positive psychology to be positive subjective experience, positive individual characteristics (i.e., strengths and virtues), and positive institutions and communities.

Positive psychology and psychotherapy. Positive psychological theory can be applied to therapeutic practice, and has been found to be useful in reducing psychological symptoms (Briere & Scott, 2012; Lambert & Erekson, 2008; Seligman, 2002; Seligman, Rashid, & Parks, 2006). A shift into positive focus versus pathological focus has been

found to be a key component of positive psychology in psychotherapy (Seligman & Csikszentmihalyi, 2000). The focus of positive psychology in psychotherapy maintains an “application of positively oriented human resource strengths, and psychological capacities that can be measured, developed and effectively managed for performance improvement” (Luthans, 2002, p. 59). For example, one positive psychology technique used in practice is to highlight and focus on patient strengths (Lambert & Erekson, 2008). Similarly, in a meta-analysis of positive psychology interventions (PPIs), Sin and Lyubomirsky (2009) established that treatments focusing on fostering positive feelings, behaviors, and cognitions as opposed to “fixing” something pathological or deficient, were effective in decreasing symptoms and enhancing well-being.

Initial evidence on PPIs focused on the incorporation of positive psychology theory in the therapeutic setting to relieve depressive symptoms (Seligman, 2002). Early evidence supported the reduction of depressive symptoms by using techniques to foster the following three components of happiness: positive emotions, engagement, and meaning (Seligman, 2002; Seligman et al., 2006). Findings further asserted that the positive effects of PPIs may not only be limited to the treatment of depression, but could also be applied to successfully treat anxiety disorders, stress, and improve general well-being (Avey, Wernsing, & Mhatre, 2011; Rieck, Shakespeare-Finch, Morris & Newbery, 2005; Sin & Lyubomirsky, 2009).

Specifically in regards to Posttraumatic Stress Disorder (PTSD), PPIs serve to reduce symptoms and foster posttraumatic growth. Tedeschi and Calhoun (1996, 2004) define posttraumatic growth as the development of a positive outlook following trauma, with which the individual may experience positive changes relating to others, new

possibilities, personal strength, spiritual change, and a new appreciation for life. Research posits that certain positively driven therapeutic techniques have the ability to enhance posttraumatic growth, versus isolation and deprivation for those who have experienced trauma (Segal, Tucker, & Coolidge, 2009). Generally, operating from a strengths-based perspective, perceiving clients as survivors versus victims, and supporting clients as they reharne their own strengths and power after a traumatic event (posttraumatic growth) are ways in which PPIs reduce negative symptoms for trauma survivors (Avey, Wernsing, & Mhatre, 2011; Briere & Scott, 2012; Josephson & Fong-Beyette, 1987; Lee, Zingle, Patterson, Ivey, & Haase, 1976; Palmer, Brown, Rae-Grant, & Loughlin, 2001).

Despite the research suggesting the effectiveness of PPIs, it should be noted that the level of success might vacillate depending upon the cultural background of each individual client. Research supports that individuals who were considered to be from an individualistic culture were found to benefit more from such treatments than those from collectivistic cultures (Sin & Lyubomirsky, 2009). Furthermore, research suggests that operational definitions of positive emotions may differ not only across cultures, but also across levels of acculturation within the same culture (Leu, Wang, & Ku, 2011). Thus, an individual's cultural background should be taken into account when deciding whether to implement PPIs (Leu, Wang, & Ku, 2011; Sin & Lyubomirsky, 2009).

Critiques of positive psychology. Although positive psychology has many benefits, there are several noteworthy criticisms of this field. For example, Miller (2008) claimed that the tenets of positive psychology are based upon faulty arguments using circular reasoning and tautology. For example Miller argues that any assertion claiming that those who are optimistic by nature are the happiest may be viewed as a simplistic

statement that merely associates mental health with a personality type. Similarly, other critics think that positive psychology may overlook the negative aspects of life, as those in the field may take a Pollyanna view of the world (Held, 2004; Lazarus, 2003). The response to these claims by positive psychologists have included an emphasis on goals to build up a knowledge base on human resilience, strength, and growth, but *not* to erase or replace work involving pathology, and dysfunction (Gable & Haidt, 2005). Gable and Haidt (2005) assert that for a successful future in positive psychology, the foci must include “striving to understand positive factors and build strengths, outline the contexts of resilience, ascertain the role of positive experiences, and delineate the function of positive relationships with others” (p. 108).

Lazarus (2003) added to the critique, noting four major methodological and conceptual limitations of the positive psychology movement. First, he highlighted the difficulties that arise with the cross-sectional nature of the research, asserting that it does not allow strong causal claims to be supported, nor does it effectively differentiate between emotional *states* and *traits*. Second, he questioned whether classifying emotions as solely negative or positive was an oversimplification. Third, he noted that individual differences are not given sufficient attention in research. Lastly, he questioned the validity of the use of questionnaires and checklists to assess complex emotional states. In sum, Lazarus (2003) critiqued the simplicity with which research in the area of positive psychology was conducted, though he supported the study of positive emotions and personality traits to improve quality of life and resources. Csikszentmihalyi (2003) responded to these assumptions, asserting that many of these critiques of positive psychological theories and methods can, in fact, be applied to other areas of

psychological research, not just positive psychology. In addition, he noted that the field may be too young to realistically expect significant longitudinal research to have been conducted and established.

Additionally critiques by Christopher and Hickinbottom (2008) and Lopez et al. (2005) include the fact that there is a lack of multicultural relevance in the scientific field of study, and that the discipline focuses on Western values, tends to be aimed towards individualistic populations, and appears ethnocentric overall. Such cultural criticisms are exemplified by the fact that although the very notion of the *self* may vary across cultures and over time, it is not considered when those in the positive psychology movement consider the *good person* or the *good life*. Positive psychologists have been challenged to be critical of the Western assumptions and values that shape their work, while integrating a diverse range of cultural meanings and values. For example, human strengths may be found in all cultures, but positive psychologists must remember that they are not necessarily universal, and it is critical that culturally and socially determined values and strengths be considered and incorporated in research (Pedrotti, Edwards, & Lopez, 2009).

Trauma from a positive psychology perspective. Extant research asserts that traditional theories and research on trauma may underestimate both an individual's ability to stay stable and healthy in the face of a traumatic event, and grow from the experience after the trauma (Linley & Joseph, 2005). Past research has tended to focus on the negative aspects of how one copes with traumatic events or stressors, but it is important to also recognize the positive aspects of how one can grow and strengthen, through resilience, during these times (Tedeschi & Calhoun, 2004). Additionally, the effects of the environment or setting in which the individual either experienced or disclosed the

trauma tend to have a significant impact on both positive and negative effects on the individual, for example leading to either posttraumatic growth and/or increased severity of symptoms and heightened prevalence of PTSD. Therefore, Joseph, Linley, and Harris (2005) suggested that researchers and theorists may better understand how people cope with stress and trauma by studying the positive change following trauma and adversity. The focus on positive change and posttraumatic growth following traumatic events can be applied to many different types of traumatic events and also to treatment-related realms, aiding in both the healing of the survivors, and those in the helping fields who may be experiencing vicarious trauma (Linley & Joseph, 2004, 2005, 2006, 2007). This subsection begins with a discussion of definitions of trauma and is followed by a description of both the positive and negative effects that trauma may have on an individual.

Definition of trauma. For diagnostic purposes the criteria in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5;* American Psychiatric Association, 2013) for the identification of Posttraumatic Stress Disorder (PTSD) includes an acknowledgement that the individual being diagnosed has experienced a traumatic event. The *DSM-5's* definition of such an event comprises part of diagnostic criterion A for PTSD, and states that individuals must meet the following criteria to have experienced a traumatic event:

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)

This definition of a traumatic event has been used widely in the field of clinical psychology, even prior to the *DSM-5*'s recent release. There is some controversy however, about whether the use of the diagnostic criterion in the *DSM-5* (and *DSM-IV-TR*, which was initially used in the present study given the *DSM-5* had not yet been released) is accurate, useful, and clinically relevant. This will be described 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 (2000) definition stated that PTSD can occur after repeated childhood sexual abuse or a single trauma threatening life or safety. In addition, an event was only regarded as traumatic by the *DSM-IV-TR* (2000) if the person experiencing it responded with helplessness, fear, or horror. Thus, there are both subjective and objective components of a trauma event as described by the *DSM-IV-TR* (2000). Therefore, psychological stress and appraisals of life events also need to be considered when discussing trauma.

The above operational definition of trauma as defined by the *DSM-IV-TR* (2000) was widely used in the field of clinical psychology and has served as a useful construct for researchers and clinicians by organizing the commonalities among various types of

trauma used in trauma research (Weathers & Keane, 2007). However, definitions of trauma vary (Briere & Scott, 2012). Similarly, many researchers and clinicians have proposed that the definition for PTSD (as defined by the *DSM-IV-TR*, 2000; and arguably the *DSM-5*, 2013) may not reflect an accurate and all-encompassing construct. Spitzer, First, and Wakefield (2007) state,

Since its introduction into *DSM-III* in 1980, no other DSM diagnosis, with the exception of Dissociative Identity Disorder, has generated so much controversy in the field as to the boundaries of the disorder, diagnostic criteria, central assumptions, clinical utility, and prevalence in various populations. (p. 233)

Prior to the new *DSM-5*'s release, researchers and clinicians tended to fall into one of two categories when proposing revision of the PTSD criteria, either to restrict or to broaden the structure and content of the criteria. Within these categories, there are a number of subsets and dimensions to be considered, discussed briefly below.

The proposal that the *DSM-IV-TR* (2000) criteria for PTSD should have been modified in a restrictive manner is one of legitimate concern. Researchers such as Norris (1992), McNally (2004), Weathers and Keane (2007), and Spitzer et al. (2007) advocate for more restrictive criteria for PTSD for a number of reasons. Reasoning includes the fact that creating more boundaries for the definition of trauma, for example, relying only on objective versus subjective criteria, would allow PTSD candidates to be separated from those who may be experiencing a normal stress reaction to adversity (Norris, 1992; Spitzer et al., 2007).

Researchers argue that with the *DSM-IV-TR* (2000) criteria, it become difficult to address those who are functionally impaired, versus those who may be more susceptible

to the individual responses that can occur from traumatic situations (Norris, 1992; Spitzer et al., 2007). This becomes problematic as the *DSM-IV-TR* (2000) definition of PTSD may be seen as having moved the field from an understanding of natural psychological responses and natural recovery of traumatic events, to pathologizing normal reactions to stress (Spitzer et al., 2007). McNally (2004) asserts that the *DSM-IV-TR* (2000; and likely the *DSM-5*) criteria of PTSD also allow for, what he calls, a “conceptual bracket creep,” in which an individual experiencing a normal stress reaction may fit into one of the “vague” categories that exist currently (Spitzer et al., 2007, p. 236). He also asserts that the new definition should not include individuals who have witnessed trauma, but only those who have experienced it directly. He proposes that those who do not fit this more specific criteria should be given the diagnosis of Anxiety Disorder NOS, or a newly introduced V code of “acute non-pathological reactions to a stressor” (p. 598).

The model for the recently released *DSM-5* by the APA Anxiety, OCD-Spectrum, Posttraumatic, Dissociative Disorders Work Group proposed a similar change to occur, 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). The proposed new Criterion A precludes those who witness the traumatic event through electronic media outlets from a diagnosis of PTSD. In addition this group suggested including an additional category such as a Trauma or Stress Related Disorder Not Elsewhere Classified, for trauma-related disorders that do not meet full or specific criteria for PTSD. These researchers worried that widening the definition of

trauma could include things that would cause distress in almost anyone, though some agree that having subjective criteria in the definition does allow for differences in individual temperament (e.g., resilience), and type, duration, proximity and intensity of the traumatic event (Weathers & Keane, 2007). They propose that a more specific tailoring of the current criteria's wording might be effective enough to address the concerns.

Another problematic issue with the broadness of the definition of the PTSD diagnosis in the *DSM-IV-TR* (2000) was that many of the criteria also overlapped into criteria for other disorders and the same occurs with new *DSM-5* definition. This can become confusing during diagnosis, considering that many symptoms of PTSD are also symptoms of Borderline Personality Disorder, mood disorders, and other anxiety disorders (Spitzer et al., 2007). Additionally, the cultural components of the definition (e.g., differences between individualistic versus collectivistic cultures) may even overlap with current or qualify as a new culture-bound syndrome (Bracken, Giller, & Summerfield, 1995; Briere & Scott, 2012). Additionally, the current criteria for PTSD is very different for the definition of trauma from the ICD-10 (e.g., no numbing criteria is included in the ICD-10's definition of PTSD), therefore including the possibility that the criteria should be restricted to correlate with international standards (Spitzer et al., 2007).

Reasoning supporting the assertion that the *DSM-IV-TR* (2000) criteria for PTSD should be broadened to encompass certain individuals, circumstances, traumas and situations that are not accounted for by the current definition is also sound. Courtois (2004) and Resick et al. (2012) correctly identify the lack of criteria needed to address a concept called *complex posttraumatic disorder* or *CPTSD*. They argue that CPTSD is an

intricate system of multiple traumatic events (e.g., repeated child sexual abuse, or multiple encounters with rape or violence over the span of one's childhood, or lifetime) that is not accurately depicted by the current PTSD definition. The argument stands that the definition must be broadened to account for those individuals who have suffered multiple traumas throughout their lives, as their PTSD may be more complex, hence CPTSD, than those who have experienced one traumatic event. Similarly, Norris (1992) proposed including potentially traumatic situations of a less severe nature that may be reinforced over time (e.g., violent encounters with humankind, technology, or nature) within the definition of PTSD. Seides (2010) also agreed that PTSD may occur from multiple, less severe trauma exposures over time. Even more specifically, Hasanoglu (2008) argued that PTSD can develop without an exposure that threatens life or physical integrity, though the current definition upholds that this criterion must be met in order to be defined as trauma in PTSD. He argued that minor emotional insults, built up over time, can lead to the same poor coping skills and extreme life stressors that those who are traumatized usually experience. Wilson (1991) agreed, but specified that experiencing constant bullying should also be included in the definition of trauma, as it can lead to minor, micro-aggressions that can negatively affect the survivor. While these researchers argue for a more subjective view of the definition of trauma, Weathers and Keane (2007) note that subjective criteria can make it more confusing for those who are diagnosing, as well as those who are experiencing the trauma (given individual differences, and the many external factors that can arise during, and after, traumatic events).

Finally, both those who promoted the inclusion of additional criteria for PTSD and those who did not, would ultimately argue that the *DSM-IV-TR* (2000) definition

lacked the consideration of cultural issues, specifically in regards to acknowledging trauma experienced by ethnic, and other, minorities (Scurfield & Mackey, 2001). There is no reference to racial violence and oppression in the form of individual or shared trauma, and there are sound arguments that both should be considered for inclusion in the next revision of the DSM (Kogan, 1993; Tummala-Nara, 2007). Additionally, as ethnic minority groups are at a higher risk for experiencing trauma and violence, the definition of trauma should be highly influenced, and all-encompassing of these individuals (Walters & Simoni, 2002). The new *DSM-5* does address this issue and includes the following information on culture-related diagnostic issues for PTSD (Hinton & Lewis-Fernández, 2011):

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

The predominant definition used in the current *DSM-IV-TR* (2000) was used for the purposes of this dissertation, given that the *DSM-5* had not yet been released. The *DSM-IV-TR* was slightly modified for this study, in accordance with suggestions 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. Examples of this, based on the Structured Clinical Interview for *DSM-IV-TR* Axis I Disorders (SCID;

First, Spitzer, Gibbon, & William, 2002) include, but are not limited to: serious accidents or fire, rape or physical assault, child sexual abuse, life threatening combat experiences, seeing another person being killed or badly hurt, and life threatening major natural disasters. Learning of an event indirectly (e.g., on television, talking to a friend) will not qualify as a traumatic experience for the purposes of this dissertation. Additionally, the person need not have a reaction that includes fear, helplessness or horror as a result of the trauma. Lastly the definition used for the purposes of this dissertation will include other forms of trauma previously discussed, such as CPTSD, as well as trauma related to cultural or race-based factors (e.g. race-related actual or threatened physical or verbal assault).

Effects of trauma. As noted above, a traumatic event can include the direct experience of an array of negative situations, such as 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). An individual may experience a primary traumatic event, which is the direct experience of any one of these events, or may have a history of chronic, multiple, or other traumatic experiences (Briere & Scott, 2012). After a traumatic event occurs, there are a variety of ways in which an individual may respond. Bonnano (2008) refers to these patterns of behaviors/functioning in response to traumatic events as *trajectories*. This subsection reviews both positive and negative trajectories to trauma.

Positive trajectories may include recovery and resilience which Bonnano (2008) describe as short term trajectories to trauma reactions. Recovery can be considered the

ability to decrease symptoms that resulted from traumatic events, over time (Bonnano, 2008). Resilience is differentiated from recovery in that these individuals exhibit minimal symptoms and maintain a relatively stable equilibrium after the experience of trauma versus recovering from those symptoms (Bonnano, 2008). These positive trajectories may lead to what is known as posttraumatic growth. In “posttraumatic growth,” an individual actually attains a level of personal psychological growth in the aftermath of the traumatic event (Linley & Joseph, 2005).

Negative trajectories include chronic disruption in individuals’ functioning, known as chronic dysfunction (Bonnano, 2008), and delayed onset of dysregulation which can increase over time (Bonnano, 2008; Courtois, 2008). Many times these long-term trajectories can stem from complex types of trauma (CPTSD), or multiple, chronic, or prolonged traumatic events (Courtois, 2008).

The experience of such disruption or dysregulation usually involves negative effects, many of which are encompassed within the *DSM-IV-TR* definition of PTSD. These may include, “recurrent and intrusive distressing recollections of the event,” “intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event,” “efforts to avoid thoughts, feelings, or conversations associated with the trauma,” “difficulty falling or staying asleep,” and “hypervigilance” (APA, 2000, p. 468). In addition, the expression of negative emotions such as fear, helplessness, anger, hostility, and interpersonal difficulties can be commonly associated with the negative trajectories following trauma and PTSD, like disruption and dysregulation (Orth & Wieland, 2006; Taft, Watkins, Stafford, Street, & Monson, 2011).

These positive and negative trajectories can be affected by a number of external variables such as prior trauma, psychological adjustment, family history of mental health issues, perceived threat to life during the trauma, social support in the aftermath of the trauma, validation or invalidation of disclosure/discussion of the trauma, and emotional responses and dissociation during the trauma (Ozer, Best, Lipsey, & Weiss, 2008). Additionally, individual factors such as ethnicity, gender, age at trauma, severity of trauma, and life stressors and support (both perceived and actual) were also significant for affecting positive and negative trajectories (Brewin, Andrews, & Valentine, 2000). Highlighted in this research is the effect of the response and reaction to the discussion of the traumatic event, after the event has occurred, which is what will be discussed in depth in the following section, Responses and Reactions to the Discussions/Disclosure of Trauma.

Common psychotherapeutic interventions for working with trauma survivors. A variety of psychotherapeutic models or theoretical approaches are employed by therapists who work with trauma survivors. Although these approaches may proclaim external differences, many of their underlying techniques have the same or similar focus: the basic helping skills taught to therapists of all orientations. In accordance with these similarities, therapists treating trauma survivors acknowledge the importance of integrating techniques to fully support their clients (Joseph & Linley, 2008; Kerig, Sink, Cuellar, Vanderzee, & Elfstrom, 2010; Mannarino & Cohen, 2000; Moss, 2009; Pitchford, 2009). For example, Moss (2009) asserts that “if ever there was a diagnostic category that calls for a multiple-therapeutic approach it is [trauma]” (p. 172).

The treatment of survivors can be complex (Kessler & Goff, 2006), and therefore training is essential for therapists who are working with trauma survivors (Gold, 1997). There is little literature regarding training in the areas of reacting to client disclosure or discussion of trauma, and how to make appropriate initial treatment decisions as a therapist (Kessler & Goff, 2006). Yet, the literature does offer treatment recommendations for providing therapy and services to populations that have suffered trauma, and identifies common factors across paradigms that may be of use during discussions of trauma (Bohart & Greenberg, 1997; Gable, Gonzaga, & Strachman, 2006; Josephson & Fong-Beyette, 1987; Kessler & Goff, 2006; Lee et al., 1976; Palmer et al., 2001). Usually presented in the early stages of a graduate training program, the basic common factors of successful psychotherapeutic intervention may allow trainee therapists to gain experience and successfully treat trauma clients, and are therefore explored next. This subsection begins with a brief review of specific treatments used with trauma survivors under the psychodynamic, cognitive-behavioral, existential, humanistic, positive psychology, and integrative trauma therapy models. It is followed with a discussion of the common factors of trauma therapy based on theoretical approaches and client testimony.

Various trauma-focused theoretical approaches. The purpose of briefly outlining various theoretical approaches to working with trauma is not to discount the complexities and sophistication of each treatment strategy, but to highlight the underlying similarities within each. These similarities include common factors, such as the importance of the therapeutic alliance, using empathy to validate the client's experience, using a strengths based approach, and using a direct approach when treating trauma survivors.

In the realm of psychodynamic theory, psychodynamic trauma treatment models tend to focus on the strength of the therapeutic alliance, rapport, transference and countertransference, and repressed unconscious conflicts in dealing with the trauma (Moss, 2009). Casement (1985) outlines the main elements of psychoanalytic psychotherapy: an analysis of the transference and countertransference, examination of outside events and their relation to the therapy, and the recovery and examination of historical memories and associated emotions, with a focus on the unconscious as reflected in the three aforementioned areas and in dreams. However, certain practitioners of the psychodynamic trauma model note the importance of an integrative trauma approach including non-traditional psychodynamic techniques such as action and body-oriented interventions and behavioral interventions to reduce anxiety symptoms and work through trauma somatically (Horowitz, 1973, 2005; Moss, 2009). Theorists note that it is important to incorporate these techniques within a psychodynamic framework, for example, paying close attention to transference, and countertransference throughout the process (Moss, 2009).

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is based out of the cognitive behavioral model, and also integrates principles from attachment theory, family systems, and humanistic perspectives (Kerig et al., 2010). These influences are seen in the major principles of TF-CBT, which include respecting culture and belief systems, a focus on the therapeutic relationship, and utilizing a strengths-based approach with the survivors; however the technique is geared towards children (Kerig et al, 2010).

For adults, cognitive behavioral methods to treat PTSD are highly recommended by expert consensus, and include exposure therapy, stress inoculation training, and

cognitive therapy (Follette & Ruzek, 2006; Hembree & Foa, 2003; Iverson et al., 2011; Woo & Keatinge, 2008). The treatment also may involve eye movement desensitization and reprocessing (EMDR) and/or pharmacological treatment for PTSD (Follette & Ruzek, 2006; Hembree & Foa, 2003; Woo & Keatinge, 2008). A focus on early intervention and the use of crisis intervention programs for survivors is also incorporated in cognitive behavioral models for the treatment of trauma (Follette & Ruzek, 2006; Hembree & Foa, 2003). Recently third-wave approaches using mindfulness have also been incorporated in working with trauma survivors (Briere & Scott, in press; Siegel, 2010; Thompson, Arnkoff, & Glass, 2011).

Existentialist approaches assert that survivors of trauma must be supported as whole beings, and be given an empathic, validating, and safe environment in which to disclose the trauma, in order to restore trust in their interpersonal relationships (Pitchford, 2009). Similarly, Humanistic trauma treatment focuses on creating a trusting therapeutic relationship, creating a safe and secure place for the discussion of trauma, and the use of unconditional positive regard and respect from the therapist (Mannarino & Cohen, 2000).

Positive psychological models treating trauma tend to focus on empathy, the therapeutic relationship, and potential for growth and recovery from traumatic events (Joseph & Linley, 2008). Treatments focus on a strength-based approach of understanding and enhancing the well-being of clients, and use both macro and micro perspectives to evaluate trauma's impact on the survivor (Joseph & Linley, 2008).

Finally, an integrative version of trauma therapy may incorporate a number of the aforementioned techniques. For example, integrative trauma therapy by Briere and Scott (2006), involves a number of important phases and considerations when conducting

therapy with trauma survivors. This approach includes an assessment phase composed of three sub-steps; addressing immediate concerns, assessing trauma exposure, and assessing effects of trauma. Addressing immediate concerns focuses on issues such as safety, psychological stability and stress tolerance. The second sub-step, assessing trauma exposure, uses rapport building to anchor a strong and trusting therapeutic relationship, using empathy and a nonjudgmental tone, being sensitive to one's voice and body language during discussions and using gentle support and validation of a client's feelings and reactions throughout the assessment. Lastly, the assessment of the effects of trauma on the survivor includes looking for process responses, activation responses, affect dysregulation, relational disturbances, and symptom responses in the survivor's presentation.

The approach by Briere and Scott (2006) focuses heavily on the therapeutic relationship, and describes the major components of establishing an effective and positive therapeutic relationship to include a positive and nonintrusive demeanor, acknowledgment of client's distress and immediate situation, explanation of the assessment and therapy process, boundaries regarding confidentiality and limits, and working to facilitate self-disclosure at the survivor's own pace. Integrative trauma therapy operates from a basic philosophy of recovery and growth, reframing many posttraumatic symptoms as adaptive and recovery-focused rather than pathological (Briere & Scott, 2012). Operating with respect and positive regard for the client, instilling hope, and providing and ensuring safety and stability in the therapeutic environment are also of utmost importance according to Briere and Scott (2006). Tailoring therapy to the client and his or her experience(s) with trauma, taking gender

issues into account and being aware of and sensitive to sociocultural issues while monitoring and controlling one's own countertransference are central to integrative trauma therapy (Briere & Scott, 2012). Finally, techniques of the treatment include psychoeducation, distress reduction and affect regulation training, cognitive interventions like cognitive processing and developing a narrative, emotional processing such as reexperiencing, exposure, activation, counterconditioning and processing "hotspots," (Briere & Scott, 2012, p. 186) increasing identity and relational functioning, mindfulness training, and trauma psychopharmacology when appropriate (Briere & Scott, 2012).

Given the personalized nature of this integrative approach (i.e., tailoring specific therapeutic interventions to the client's individual factors and trauma experiences in the context of a unique therapeutic relationship), randomized controlled trial studies are difficult to implement. Despite research challenges, integrative trauma therapy has been studied among children, adolescents, and young adults, albeit none with randomized control studies (Lanktree & Briere, 2008). The studies of the integrative model for children and young adults (which mirrors the integrative model for adults) conducted in a four year federally-funded project provides evidence that the treatment reduces symptoms among these populations (Briere & Lanktree, 2011). Other studies of this treatment with clinic-and school-based multiply traumatized children revealed significant reductions in trauma-related symptoms, such as PTSD, depression, anxiety, and dissociation (Briere & Langtree, 2011; Lanktree & Briere, 2008)

Central factors in trauma therapy. The aforementioned theoretical approaches to trauma treatment include a number of central factors that are consistent with the basic skills needed for helping professions. The importance of the therapeutic alliance (e.g.,

establishing rapport, trust, and a safe environment), using a strengths based approach (empowering the client and instilling hope), being validating and empathetic (exhibiting unconditional positive regard, being nonjudgmental and understanding), and using a direct approach when treating trauma survivors are all common factors that this author has identified among the various theoretical approaches in treating survivors of trauma.

In addition, Palmer et al. (2001) conducted research in which they investigated the survivor's perceptions of their experiences with professional helpers, and found that clients found empathy, directly dealing with feelings, being nonjudgmental and understanding, validating the survivor's experience, and feeling empowered instead of controlled were the most helpful aspects of meeting with a professional helper. The authors note that the common factors valued by the respondents are consistent with the basic skills needed for helping professions; listening in an empathic way, dealing with feelings, and being nonjudgmental.

Therefore, there are certain tenets that both therapists of many theoretical orientations and survivors of trauma agree are central to the treatment of trauma. This literature review groups these characteristics into four main categories: the importance of the therapeutic alliance, using empathy to validate the client's experience and create a safe environment for trauma discussion, using a strengths based approach, and using a direct approach when treating trauma survivors. These four tenets will be discussed in relation to trauma treatment.

Therapeutic alliance. Creating and maintaining a strong therapeutic alliance is important when treating a survivor of trauma. Although some therapeutic approaches may stress the dynamics of a therapeutic relationship more than others, it is documented

that all forms of therapy work better if the client feels a strong bond with her therapist, feeling accepted, liked, and taken seriously (Briere & Scott, 2012). Miller, Duncan, and Hubble (1997) found that the therapeutic relationship accounts for more than 35% of the variance of efficacy in counseling, which speaks directly to the importance of the relationship in therapeutic effectiveness.

In working with trauma, many times the traumatized individual has experienced a shattering of their environment as a result of the trauma, and thus creating a safe and supportive environment through strong rapport is key (Moss, 2009). Additionally, a positive therapeutic alliance may result in a variety of benefits for the client, such as less avoidance of personal material, greater disclosure rates, decreased treatment drop-out and more reliable attendance, greater treatment adherence, greater openness to and acceptance of therapist interpretations, suggestions and support (Briere & Scott, 2012; Farber & Hall, 2002; Frank & Gunderson, 1990; Horrvath & Luborsky, 1993; Rau & Goldfried, 1994). By using verbal and nonverbal displays to strengthen the therapeutic alliance, the client may perceive the therapist in a more positive light than those who have weak rapport with their therapist or perceive their therapist negatively (Lee et al., 1976). Finally, having a strong therapeutic alliance allows the opportunity to process traumatic activations and emotions in the context of a caring, safe, and supportive environment with the therapist (Briere & Scott, 2012).

The above factors mentioned by clients are factors that are common among many different types and styles of therapeutic interventions and each lead to the creation of a strong therapeutic alliance. Therapists can express these factors verbally and non-verbally, and research posits that clients tend to feel most secure in therapy when the

therapist expresses positive responses to disclosure via both means (Lee et al., 1976). Therapists who use effective verbal responses in conjunction with effective non-verbal responses tend to be better perceived by clients, and in such cases of trauma discussion, may be perceived as having a more positive reaction to the discussion (Lee et al., 1976). Lee et al., 1976 also found effective verbal responses to include accurate reflection of feeling and paraphrasing, whereas effective nonverbal responses tended to include eye contact, body trunk lean, concerned expression, and physical closeness to the client. These actions can lead to the client feeling safe and supported, and create a nonjudgmental platform for the clinician to respond from (Lee et al., 1976; Schachter, Radomsky, Stalker, & Teram, 2004). Accepting, validating, and encouraging the client are other beneficial tools that are conveyed to clients via the accurate reflection of feeling and paraphrasing (Lee et al., 1976; Palmer et al., 2001; Weaver, Varvatto, Connors, & Regan-Kubinski, 1994).

Empathy. Empathy tends to be a common factor among therapeutic interventions, including those involving the discussion of or disclosure of trauma. Though empathy is recognized as playing a major part in client-focused approaches, it is acknowledged as universal as far as client communication in the therapeutic dyad (Bohart & Greenberg, 1997; Herman, 1981; Higgins, Kessler, & Goff, 2006; Josephson & Fong-Beyette, 1987; Palmer et al., 2001). Empathy has been named “an essential ingredient of therapeutic practice, and a key concept in attempts to understand how therapy works” (Bohart & Greenberg, 1997, p. 4), no matter the therapist’s orientation. Many therapists use empathy as a way to connect with the client and their understanding and support in the context of trauma (Palmer et al., 2001). Clients have named empathy as being a very

important tool in therapy during the discussion of trauma (Josephson & Fong-Beyette, 1987).

The expression of empathy can lead to a more comfortable, validating experience for the individual who is disclosing or discussing a traumatic event, and allow he or she to feel connected to, and supported by the therapist. Empathy in itself is validating, as it acknowledges the client's distress, and adds an element of understanding to the discussion of his or her personal traumatic event in a nonjudgmental manner.

Strengths based approach. Another common factor in trauma therapy tends to be operating from a strengths based perspective or from a positive psychological perspective. Therapists who perceive clients as survivors versus victims, those who have knowledge and training in the area of trauma, and those who encourage clients, and promote strength and posttraumatic growth tend to be identified as the most helpful by clients who are treated for trauma (Josephson & Fong-Beyette, 1987; Lee et al., 1976; Palmer et al., 2001). Additionally, emphasis on the survivor's innate tendency to process trauma-related memories and to move toward adaptive psychological functioning, versus labeling pathological symptoms can be used in trauma treatment (Briere & Scott, 2012). This shift in focus helps to reframe posttraumatic symptoms as adaptive and recovery focused versus pathological. Highlighting that trauma can result in growth such as new levels of resilience, enhanced or additional survival skills, greater self-knowledge and self-appreciation, increased empathy, and a more broad and complex view of life is also helpful for trauma survivors during therapy (Briere & Scott, 2006). Finally, empowering clients versus controlling them (Palmer et al., 2001), and instilling hope and an overall positive view of the client and his or her future is often justified and helpful. Noting signs

of improvement whenever they occur and communicating guarded optimism when appropriate highlight a strengths based approach (Briere & Scott, 2012).

Direct approach. Finally, clients and theorists agree that as long as the survivor is not in current crisis or severe distress, a direct approach to gathering, assessing for, and working-through trauma is preferred. Specifically, clients named that they had more trust in therapists who actively addressed their trauma (Josephson & Fong-Beyette, 1987). Research supports that addressing the trauma in an active versus passive way is helpful to clients when discussing the trauma personally, or in therapy (Gable et al., 2006; Josephson & Fong-Beyette, 1987). Research posits that in the therapeutic relationship, an active, direct stance by the therapist leads to a more comfortable discussion of therapy for the client (Josephson & Fong-Beyette, 1987). This makes sense, as the clients are seeking help from professionals who they hope are knowledgeable, nonjudgmental, and understanding. However, Briere and Scott (2006) caution therapists to avoid direct or intrusive questioning that might feel demeaning or interrogating, and instead work to facilitate the client's self-disclosure at his or her own pace and level of specificity.

Discussion of Trauma in Therapy

Studies suggest that a key feature in resolution of a stressful or traumatic event is involvement in the disclosure and discussion process (Lutgendorf & Antoni, 1999). There are many ways in which an individual can become involved in this process, whether through positive or negative discussion, verbal or written discussion, and/or by discussing their thoughts and emotions regarding the traumatic event. Despite the fact that research suggests the disclosure and discussion of trauma to be critical steps to receiving aid for dealing with traumatic experiences, there are many factors that are considered by the

survivor before deciding to disclose or discuss the trauma (Ming-Foynes, Freyd, & DePrince, 2009).

Moreover, many victims may be hesitant to disclose traumatic events to others (Deblinger et al., 2011; Rieck et al, 2005; Segal et al., 2009; Sorsoli, 2010). Research notes that delayed and non-disclosures are common among survivors, especially survivors of stigmatizing traumas (e.g., child-sexual abuse, rape, physical abuse; Ming-Foynes et al, 2009). Additionally, sociocultural circumstances have been found to affect the decision to disclose such as ethnicity/acculturation level, gender, and age (Briere & Scott, 2012; Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003; Martsof et al., 2010; McCormick, 2007). Personal reasons for non-disclosure surrounding these often stigmatizing events may include survivor self-blame, and feelings of shame as well as fear for physical safety upon disclosing (Ullman & Filipas, 2001; Ullman, Starzynski, Long, Mason, & Long, 2008). Other reasons for non- or delayed-disclosure include how much risk may be anticipated in disclosing, anticipated negative responses, and the relationship with whom the person is planning to disclose (Derlega, Winstead, Green, Serovich & Elwood, 2004; Goodman-Brown et al., 2003).

This section first discusses the definitions of the disclosure and discussion of trauma, then addresses different factors that may impact the decision to disclose. Next it outlines ways of and types of disclosure, followed by the outcomes of disclosing/discussing a traumatic event. Lastly, recommendations are given for therapists to empower them in promoting disclosure among survivors.

Definitions of disclosure and discussion of trauma. When an individual decides to share information with another, the sharing process can be referred to as disclosure. It

is important to note the relational aspect of the word disclosure, versus a more intrapersonal approach, like remembering (Sorsoli, 2009). In the area of trauma, disclosure usually refers to the first time a person has shared information about a traumatic experience with another (Chaudoir & Fisher, 2010; Lutgendorf & Antoni, 1999). A first-disclosure could refer to the first time a person has ever disclosed information after the trauma has occurred, or it could refer to the first time the disclosure has been made to a certain individual (e.g., a survivor discussed the trauma with his wife in the past, but he waited until the 5th session to disclose the trauma to his therapist). For the purposes of this study, the word disclosure will refer to the first time a trauma survivor discusses the information about the trauma with his or her therapist.

The disclosure of traumatic events can be a truly complex process that involves sustained self-regulatory efforts on behalf of the survivor (Chaudoir & Fisher, 2010). In their Disclosure Processes Model, Chaudoir and Fisher (2010) describe disclosure as a three-part process that includes, deciding to disclosure trauma by exerting self-control, being able to communicate the information about the trauma in an effective manner, and being able to cope with the outcomes and consequences of the disclosure. For those individuals who are concealing a stigmatized identity, such as survivors of child sexual abuse (CSA) and/or rape, the disclosure process likely entails an even more complex level of decision making which is explored further in the next subsection.

Although individuals may disclose their traumas more than once, it may be rare that they continually discuss their trauma with any one individual (Linehan, 1993). The discussion of traumatic events, therefore, refers to on-going conversation about the event(s). A discussion about trauma can range anywhere from once after a disclosure, to

many hours, days, weeks or years of discussion. Research supports the idea that increased negative mood and sadness may increase during an initial disclosure; however research finds that mood recovery usually occurs by the third discussion of the traumatic event (Lutgendorf & Antoni, 1999), making it all the more important to continue discussions of trauma. For the purposes of this study, the word discussion will refer to the before, during, and after phases described in the DPM model that speak to the on-going and continual pattern of disclosing trauma related information (Chaudoir & Fisher, 2010). Discussion therefore includes elements of self-control, effective communication including descriptions of the traumatic event, evaluative content about the traumatic event, and affective content regarding the traumatic event and coping skills to deal with outcomes and consequences of the discussion (Chaudoir & Fisher, 2010; Chelune, 1979; Jourard, 1971; Omarzu, 2000; Pennebaker, Zech, & Rime, 2001).

Factors involved in the decision to disclose or discuss trauma. There are a number of factors that contribute to the complex process of deciding to disclose or discuss trauma, especially for those who are concealing a stigmatized identity (e.g. survivors of sexual abuse, rape, domestic violence). Personal factors, social influence, sociocultural circumstances, and situational limitations can each influence a survivor's decision to disclose or discuss the trauma (Chaudoir & Fisher, 2010; Lutgendorf & Antoni, 1999; McCormick, 2007; Ming-Foyne et al., 2009; Rieck et al, 2008; Ullman, 2007). This subsection discusses these factors and how they affect a survivor's decision to disclose or discuss trauma.

Personal factors. Personal factors, such as approach versus avoidance goals, neuropsychology, the presence of self-blame attributions, and one's ability to handle

intense emotions, may impact the survivor's willingness and ability to disclose and discuss trauma (Chaudoir & Fisher, 2010; Krause, Mendelson, & Lynch, 2003; Sorsoli, 2009; Ullman, 2007). Chaudoir and Fisher (2010) categorize individuals who are deciding whether or not to disclose sensitive information into two groups based on specific personal factors. The two categories include distinct psychological profiles for individuals who possess (a) approach goals or (b) avoidance goals. It is important to note that Chaudoir and Fisher (2010) highlight fundamental differences in regards to each group's self-regulatory efforts and foci. For example, they describe that individuals with approach goals may be focused on the possibility of positive outcomes, aiming to move towards possible rewards and positive emotional states. On the other hand, they indicate that those who possess avoidance goals may be focused on the possibility of negative outcomes, and their efforts at self-regulating tend to be aimed specifically at moving away from negative states and/or punishments.

Similarly, Lutgendorf, and Antoni (1999) posit that trauma is processed, especially in those diagnosed with PTSD, through a cycle of intrusion and avoidance that protects individuals by allowing them to process information in small doses. Survivors who fixate on either the intrusive or avoidant aspects of a traumatic event may create a barrier to disclosure, whereas those who engage in the cycle increase processing of the traumatic information and allow themselves to slowly discuss and disclose traumatic information, promoting future discussion (Lutgendorf & Antoni, 1999).

For those individuals who have experienced multiple or complex trauma, or those who have moderate to severe PTSD, an avoidance goal profile tends to be typical (Chaudoir & Fisher, 2010; Krause et al., 2003; McCormick, 2007; Ullman, 2007). In

relation to trauma disclosure and discussion, research indicates that these individuals with higher levels of avoidance tend to be associated with lower levels of disclosure than those with approach goals (Chaudoir & Fisher, 2010; Krause et al., 2003; McCormick, 2007).

Studies of brain lateralization indicate that traumatized individuals may be also less likely than other individuals to logically and sequentially organize and categorize their perceptions, making it more difficult for these individuals to create a trauma narrative or disclose/discuss a traumatic event with others (Sorsoli, 2009). These neuro-physiological complications can limit and even silence those who have experienced trauma, and may even affect memory pathways that would allow the disclosure or discussion of the trauma with others (Sorsoli, 2009).

Additionally, those individuals who are likely to have self-blame attributions, or feelings that the traumatic event was somehow their fault, or that they deserved the traumatic event may be at increased risk for delayed or non-disclosure as well (Goodman-Brown et al., 2003; Sciolla et al., 1997; Ullman, 2007). These self-blame attributions tend to be common among certain trauma survivors, especially those who have experienced prolonged or complex traumas (Briere & Scott, 2006). Additionally, individuals who have experienced what are known to be “betrayal traumas” or those in which the perpetrator was a close family member, tend to have higher levels of self-blame attributions as seen in research by Ullman (2007). Finally, in a study with African America and Latina women, participants with high levels of self-blame attributions were less likely to disclose and also experienced increased levels of depression symptoms than those with low levels of self-blame attributions (Sciolla et al., 1997).

Regarding personal emotions, Linehan (1993) noted that individuals who have experienced traumatic events or negative life events, especially those who have experienced chronic traumas, tend to be less successful at achieving emotional regulation than those individuals who have not experienced traumas. Given this information, in combination with the extant research stating that an individual's emotional distress may temporarily increase upon disclosure, research indicates lower rates of disclosure and discussion of trauma for those who have experienced complex trauma or moderate to severe PTSD than for those who have experienced mild traumatic events or PTSD (Krause et al., 2003; Sorsoli, 2009; Ullman, 2007).

Social influence. A survivor's ability to disclose may be also impacted by his or her social interactions and his or her anticipation of how the disclosure will be received. Extant research indicates that socially, the targets for the discussion of important events tends to be close relationships partners, defined by Gable, Gonzaga, and Strachman (2006) to be spouses, parents, best friends, or roommates. In a professional setting, the social exchange of a disclosure or discussion regarding a traumatic event may be considered one that occurs during the duration of a therapeutic relationship.

A key variable of fear of negative consequences when disclosing tends to be consistently found across studies for both children and adults who have experienced trauma (Gable et al., 2006; Goodman-Brown, et al., 2003; Lippert, Cross, Jones, & Walsh, 2009; Shenk & Fruzzetti, 2011). Such negative consequences include being rejected or avoided by the listener, being shamed or scolded, or being humiliated or invalidated (Chaudoir & Fisher, 2010; Linehan, 1993; Shenk & Fruzzetti, 2011). Also, a survivor's perceived level of blame or responsibility to trauma is a social factor that

might impact a child or adult's disclosure of a stigmatized trauma, as seen in research by Goodman et al., (2003), Lippert et al. (2009), and Ullman (2007).

One's ability to disclose may also be impacted by worries how the disclosure will affect others, and whether relationships will be impacted (Sorsoli, 2004). Research involving victim-perpetrator closeness and the idea of the betrayal theory posits that those in very close relationships with perpetrators who cause them physical or sexual trauma were significantly more likely to never disclose, or to wait one or more years to disclose, than wait less than one year (Ming-Foyes et al., 2009). In child sexual abuse cases, children from incestuous families, or those who knew, or had a familial relationship with the perpetrator tended to take longer to disclose, if ever disclosing (Goodman et al., 2003; Kogan, 2004; Lippert et al., 2009).

Perceived invalidation, usually based on past invalidation, tends to be an influencing factor for non-disclosure as well (Hong et al., 2011; Linehan, 1993). Perceived invalidation includes any response that the discloser categorizes as being invalidating (e.g., ignoring, negating, trivializing, responding inappropriately to their thoughts and feelings), and is likely influenced by the client's state of mind, current mood state, diagnosis or past history (Hong, et al., 2011). It is the perception of the discussion or disclosure that may have a negative impact upon the client, even when the individual's perception may not be congruent with the actual response of the listener (Hong et al., 2011; Rieck et al., 2005).

Similarly, an experience of childhood emotional invalidation and abuse may lead an individual to experience difficulties in emotional regulation, described earlier in the personal factors subsection, which may influence their social behaviors. For example,

these individuals may use an over-reliance on avoidant regulating strategies or create a barrier to disclosure on an interpersonal level (Krause et al., 2003). They also might learn to expect invalidation from those whom they disclose to (Sorsoli, 2004). Individuals who experience large levels of invalidation throughout their lives tend to adopt a coping style where suppression or avoidance is used to regulate emotions (Shenk & Fruzzetti, 2011). Likewise, this style of interaction, which is a personal factor as well, may affect their personal or social interactions, as they tend to avoid and suppress the negative emotions or discussion of traumatic events when interacting with others (Shenk & Fruzzetti, 2011). Finally, on a behavioral level, disclosure has not proven to be beneficial for the survivor in circumstances where the survivor receives negative feedback, thus lessening the chances for future disclosures or discussions of trauma (Ming-Foynes et al., 2009).

Sociocultural circumstances. Sociocultural circumstances are also likely influential in a survivor's decision to disclose/discuss trauma. Little research considers the ways in which disclosure delays and socio-cultural pressures for silence appear in narratives for trauma survivors (Sorsoli, 2009).

A salient sociocultural variable appears to be the type of trauma experienced. Different types of trauma may interact with different levels of social-acceptability in disclosing and ultimately create barriers to disclosing. For example, traumatic events such as natural disasters may promote a sense of community, support, and bonding amongst survivors, volunteers and community members, whereas traumatic events such as sexual abuse may carry a stigma that serves to be unduly isolating to its survivors. Research posits that survivors of child sexual abuse when compared to survivors of other, less stigmatizing traumas, are least likely to disclose and may face added socio-cultural

pressures for silence given the nature of their experiences and situational circumstances (e.g., may be living with the perpetrator; Kogan, 2004; Sorsoli, 2009; Ullman, 2007).

Regarding age, research among children who had experienced child sexual abuse suggests that older children tend to disclose less often than younger children (Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003; Kogan, 2004; Ullman, 2007).

Additionally, in childhood, disclosure is often met with more negative reactions and consequences (usually discipline); therefore, children are less likely to disclose traumatic experiences than adults (Krause et al., 2003).

Gender research among male and female college students posits that males tend to disclose both trauma, and the associated emotions less often than females (McCormick, 2007). McCormick (2007) found that in general, females were more willing to share emotions and experiences than men, but the females who had experienced trauma were less likely to share emotions than those females who had not experienced trauma. These results were similar for children, in that girls tended to disclose more often than boys (Goodman-Brown et al., 2003).

Additionally, the nature of individuals' culture/ethnicity, for example, whether they call for silence and individualism, or openness and collectivism, can be influential in their decision to disclose. For some cultures, it is unacceptable for a child to question or challenge an elder or adult's view; therefore, children from these cultures may tend to be silenced more often (Sin & Lyubomirsky, 2009; Sorsoli, 2009). Additionally, literature suggests that victim blaming and race-gender stereotyping are still common within the African American community and therefore, African American women may be less likely than Caucasian women to disclose as they may be more likely to receive more negative

and/or judgmental responses when they disclose (Jacques-Tiura, Tkatch, Abbey, & Wegner, 2010).

For other stigmatized individuals, they may fear that disclosure or discussion of the trauma may bring about discrimination, hate crimes, or invalidation. The reality of the situation tends to be consistent with these beliefs, in that many times disclosure can actually increase the frequency with which people are discriminated, rejected socially, or invalidated (Major et al., 1990; Ullman, 1996, 2003). Therefore, depending upon the context of the event, the characteristics of the surrounding population and potential listeners, and the dynamic between the discloser and listener, disclosure can actually carry the danger of potentially severe and lasting harmful social consequences. Ways to protect against danger include finding individuals who may have shared the same stigmatized attribute or shared traumatic experience, or by empowering the survivor to raise awareness about and ultimately reduce the stigmas associated with the identity or traumatic event being disclosed (Cain, 1991; Corrigan 2005)

Situational limitations. When deciding to disclose or discuss a traumatic event, situational limitations of the survivor must also be taken into consideration. For example in situations where the survivor's safety may be in jeopardy if she discloses/discusses the trauma immediately, delaying or non-disclosure during that time, may actually be beneficial for the safety of the individual (Linehan, 1993; Ming-Foyes et al., 2009). Examples of situational limitations include a child who is experiencing sexual abuse but is also living with the perpetrator and has no plan of future action or options to live with others after disclosing, and/or an individual who is experiencing domestic violence and is still currently in the situation, who may be physically harmed or killed by the perpetrator

if she discloses (Linehan, 1993; Ming-Foyne et al., 2009). Additionally, younger children who may be experiencing incest by family members may lack the control to do something about the situation after disclosing, which can lead children and adolescents not to disclose (Ullman, 2007).

Ullman (2007) found that the timing and nature of the disclosure has been found to be important for individuals who are deciding if they should disclose trauma or not, especially for children. For example, a child may first decide whether the timing is safe for her to disclose trauma based on any number of factors, including the listener's perceived mood, whether the listener is alone or in a group, the current topic of discussion, and whether the listener has asked her directly about traumatic events (Kogan, 2004; Ullman, 2007). Additionally, the child will decide to whom to disclose (e.g., peer group, teacher or other authority figure, older sibling, parents), based on level of safety, closeness, availability and timing factors (Kogan, 2004).

Types of disclosure. Another aspect of the complex process of discussing or disclosing a traumatic event is the different characteristics and types or ways of disclosing. Chaudoir and Fisher (2010) acknowledge the complexity of the disclosure event by identifying depth, breadth, and duration as critical characteristics of the disclosure event. The term depth is meant to measure how intimate or private the information being shared is to the discloser, while breadth is meant to describe the amount or number of topics covered during a disclosure event. Duration is meant to encapsulate the amount of time an individual spends disclosing, whether it be at great lengths, or briefly. Depth, breadth, and duration interact with the content of the disclosure (i.e., positive/negative perspective and/or cognitive/affective content), and the method of

disclosure (i.e., verbal/written). Each of these types of disclosures and decision points in the disclosure process are addressed later, with a synopsis of positive and negative discussion first.

Positive and negative discussion. Positive disclosure or discussion of a traumatic event is one in which the positive aspects of the survivor's experience are explored (i.e., the posttraumatic growth, or any positive aspect of the traumatic event itself including the survivor's emotional or cognitive growth, strength, and resilience, and altered perceptions of the trauma that include a positive outlook). Negative disclosure or discussion of a traumatic event is one in which the negative aspects of the survivor's experience are explored (i.e., the negative events that occurred or the negative cognitions or emotions that the survivor experienced, including fears, sadness, anger, and anxieties).

Research supports the idea that both positive and negative disclosures are beneficial forms of trauma-related discussion when compared to no disclosure or discussion (Segal et al., 2009). Positive expression of a traumatic event, including discussion of positive emotions, has been found to improve individuals' perception of themselves, and the traumatic event (Segal et al., 2009). By using positive ruminations and altered perceptions of the trauma in combination with increased social supports, survivors may be less likely to feel isolated and may be able to achieve posttraumatic growth (Segal et al., 2009).

Negative expressions or those that include both positive and negative expression at once have been found to increase the survivor's well-being; however, they also tend to increase the survivor's negative affect. The focus on negative aspects of the trauma can decrease the survivor's mood, and increase emotional dysregulation (Linehan, 1993;

Sorsoli, 2009). Therefore, while both are effective in increasing overall well-being, positive expressions have been found to be equally, if not more effective than negative expressions as they do not have a negative effect on survivor's affect (Segal et al., 2009).

Cognitive and affective discussion. Cognitive discussion is the discussion of thoughts, thought processes, and belief systems that have been affected by, or experienced during, a traumatic event. Affective discussion is the discussion of feelings, mood, or affect in regards to a traumatic event, either occurring during the traumatic event, or after the event. Both cognitive and affective discussion can occur as content within the complex event of disclosure/discussion.

Research underscores the importance of recognizing both cognitive and affective components in the discussion and disclosure of trauma in therapy (Lutgendorf & Antoni, 1999), and suggests that both factual and emotional disclosures are necessary for change in both therapeutic and non-therapeutic contexts (Pennebaker & Beall, 1986). The very act of expression involved in disclosure forces individuals to place a cognitive structure on their experiences, allowing them to process them more thoroughly (Segal et al., 2009). The other vehicle for change is the evocation of emotion, negative or positive, because it promotes the assimilation of new information about events and may allow individuals to reduce their own perceived affective intensity of the event, while simultaneously gaining an increased sense of control over their emotions (Lutgendorf & Antoni, 1999). Detailed disclosure of thoughts and feelings surrounding the trauma appears to be effective in enhancing self-regulation and feelings of control of the situation (Hemenover, 2003). Similarly, the expression of cognitions and affect surrounding the traumatic event has been linked to higher levels of insight and meaning-making for individuals, leading to

higher levels of self-esteem, resilience, improvements in physical health and work and school performance (Pennebaker, 1997; Pennebaker, Kiecolt-Glaser, & Glaser, 1988).

Although both cognitive based and emotionally based disclosures are fundamentally important in building relational intimacy, there is evidence to suggest that emotional disclosures create higher levels of intimacy when compared to factual disclosures (Chaudoir & Fisher, 2010; Reis & Shaver, 1988); greater levels of affective discussion tend to promote intimacy in the interpersonal relationship at hand, whether it be therapeutic or non-therapeutic (Pennebaker, 1997). Moreover, Laurenceau, Barret, and Pietromonaco (1998) found evidence to support the idea that self-disclosure of emotion is a strong predictor of intimacy, but self-disclosure of facts is not related to intimacy between social partners. These emotional disclosures tend to be considered more private aspects of the disclosure as they are personal in nature and are considered to have greater depth (Chaudoir & Fisher, 2010). Given these findings, affective-based disclosures may be a more effective way to facilitate disclosure and discussion of traumatic events, and may even be viewed in a more positive way by listeners when compared to fact-based disclosures (Chaudoir & Fisher, 2010).

Still, both affect and cognition should be considered together to facilitate the disclosure and discussion of traumatic events. Research supports that affectively overwhelming experiences may result in storing emotions without a relevant cognitive schema, making it difficult to achieve integration of emotions and cognitions within the survivor's mental schema of the trauma (Lutgendorf & Antoni, 1999). For successful treatment, modifying the schema surrounding the traumatic event is necessary so that it is

well organized, facilitating emotions that are controlled and understandable to the survivor (Lutgendorf & Antoni, 1999; Segal et al., 2009).

Verbal and written discussion. Verbal discussion of a traumatic event is one in which an individual expresses any aspect of the occurrence to another person by oral communication (e.g., talks about what happened, how he felt, what she was thinking). Written discussion of a traumatic event is one in which an individual expresses any aspect of the occurrence to another person by written communication (e.g., writes about what happened, how they felt, what they were thinking). Given the technological advancement of our society, these definitions can include discussion via multiple media (e.g., verbal via telephone, skype, or facetime; written via longhand writing, typing, text message, social media, blog). For the purpose of the literature reviewed below, unless otherwise specified, verbal discussion will refer to in-person oral communication, whereas written discussion will refer to longhand writing.

Certain therapeutic techniques incorporate both verbal and/or written disclosure and discussion of traumatic content as their main treatment component (e.g., exposure therapy, TF-CBT, narrative therapy). Similarly, when conducting research about trauma with survivor populations, participants may be asked to retell or write about the traumatic event in a certain way (e.g., talk about the factual events versus talk about the emotional components; Chaudoir & Fisher, 2010). Both techniques can also be used casually, in a non-therapeutic/research environment, as these types of disclosure/discussion are utilized by survivors in many parts of the world.

Research posits that both written and verbal disclosure and discussion of traumatic events may lead to reparative and positive outcomes for survivors (Deblinger et

al., 2011). Theories regarding written and verbal discussions of trauma acknowledge that the act of expression involved in written or verbal disclosure forces individuals to place a cognitive structure on their experiences (Pennebaker & Francis, 1996). Because individuals attempt to express themselves via a coherent message, having to reorganize and restructure the content to make it understandable to others and allows for the survivor to gain a greater perspective on the traumatic event, potentially challenging or expanding its meaning (Lutgendorf & Antoni, 1999). Verbal or written narrative theories allow for the survivors to use meaning-making as well as cognitive processes to create a coherent representation of the trauma in the context of an individual's overall life story (Freer, Whitt-Woosley, & Sprang, 2010).

When comparing the utility of written and verbal expressions of traumatic events, both may be helpful in different ways. Verbal expression allows for connection, thought re-structuring, and opportunities for positive responses from the listener, whereas written expression tends to be a less interpersonal form of expression, in which anticipated invalidation may be lessened (Segal et al., 2009). Written disclosure can be an integral part of focusing on the alleviation of the survivor's inhibition to disclose, in that it allows an individual to express pent up emotions and thoughts (Chaudoir & Fisher, 2010; Pennebaker, 1995). Additionally, written disclosure has the ability to remain a completely individual process rather than a social process, which can be beneficial for those with concealed-stigmatized identities as the lack of interpersonal or social sharing in the process lessens negative consequences from others (e.g., prejudice, negative outcomes; Chaudoir & Fisher, 2010).

Research supports the use of written disclosure as a key part of trauma treatment. As noted above, it is important to incorporate a written component in treatment with adults because it may aid in the survivor's decision to disclose (Sloan, Marx, & Greenberg, 2011). In regards to Trauma-Focused CBT (TF-CBT) for children, research supports the idea that a written narrative or written component of treatment in which the survivor can express the traumatic event is a necessary piece of treatment, as children with the written narrative component saw greater improvements in symptom relief than those children who did not have a written component included in their treatment (Deblinger et al., 2011). Additionally, for adults, written-positive (versus written-negative, verbal-positive, or verbal-negative) expression tends to be the most comfortable for survivors, while also being effective in decreasing symptoms of PTSD and increasing general well-being (Segal et al., 2009). However, written interventions for trauma that stand alone may not be efficacious interventions for PTSD because they lack the same level of social-sharing found in verbal interventions, and do not provide the client with the opportunity to orally/verbally re-organize and make sense of the information (Segal et al., 2009).

Furthermore, within the written category of disclosure, there have been found to be significant differences in the delivery of the written information. For example, in a study looking at typing versus longhand written trauma narratives, results indicated that longhand written narratives tended to produce higher levels of negative affect than typing, ultimately leading to more self-rated disclosure (Brewin & Lennard, 1999).

Outcomes of disclosure and discussion. With regard to the last part of the DPM model, the disclosure and discussion of trauma in any form contributes to different

outcomes for the survivor (Beutler & Hill, 1992; Bradley & Follingstad, 2001; Briere & Scott, 2012; Chaudoir & Fisher, 2010; Greenberg & Stone, 1992; Krause et al., 2003; Lutgendorf & Antoni, 1999; Martzolf et al. 2010; Rieck et al., 2005; Ulman, 2007). This section discusses the various outcomes of disclosure and discussion of trauma, namely the benefits of disclosure, and the function that withholding disclosure may serve for some individuals.

There are many benefits that accompany disclosing or discussing trauma, such as the possibility of reparative, restorative and positive outcomes for the survivor (Deblinger et al., 2011; Rieck et al, 2005; Segal et al., 2009). Research indicates that improved physical and mental health can be attained by sharing one's traumatic experience with others (Bradly & Follingstad, 2001; Murray & Siegel, 1994; Pennebaker & Francis, 1996). Improved psychological, physical and behavioral well-being is documented to be related to the disclosure and discussion of traumatic events as well (Chaudoir & Fisher, 2010; Greenberg & Stone, 1992). Additionally, disclosure can create increased relationship intimacy (as previously discussed), which has been identified through previous research as the critical mediating process in developing trust within interracial group interactions (Chaudoir & Fisher, 2010; Turner, Hewstone, & Voci, 2007).

Additionally, the interpersonal disclosure process may affect dyadic outcomes, such as levels of liking, intimacy and trust, as well as social contextual outcomes such as cultural stigma (Chaudoir & Fisher, 2010; Greenberg & Stone, 1992; Simoni & Pantalone, 2005; Ullman & Filipas, 2001; Zea, Reisen, Poppen, Bianchi, & Echeverry, 2005). These domains can be affected in a positive or negative way, depending upon the interplay among the survivor's alleviation of inhibition, social support reactions, and

changes in social information (Chaudoir & Fisher, 2010). For example, by disclosing one's history of trauma, the individual disclosure can create awareness about who the person is, reduce associated stigmas, and can help to create a "norm" of disclosure in the community to which it was disclosed (Chaudoir & Fisher, 2010).

On the other hand, inhibiting emotional expression and delaying disclosure may serve a functional purpose in some cases. For example, there may be immediate physical danger for the survivor if he discloses a traumatic experience (e.g., a child who lives with the perpetrator of CSA; a partner who could be harmed in a domestic violence situation) (Iverson et al., 2011; Martsof et al., 2010; Rose, 2002).

Yet, the suppression of disclosure/discussion may still lead to later negative consequences (Krause et al., 2003). The process of non-disclosure or by inhibiting discussion of a traumatic event may require physiological effort and high levels of expended energy which can lead to increased physiological demands and stress (Harber & Pennebaker, 1992). For example, chronic thought withholding and thought suppression may be linked to psychological distress in childhood, and an increased vulnerability to and higher rates of PTSD during adulthood (Glover et al., 2010; Krause et al., 2003).

In such cases, allowing disclosure can serve as a way to alleviate physiological stress, and consequently, improve the individual's physical health. Disclosure and discussion can also serve as an exposure technique in which the individual counter-conditions anxiety and negative affect associated with the memory of the event (Foa & Kozak, 1986), thus lessening symptoms of anxiety and other mental illnesses.

Promoting disclosure in the therapeutic relationship. In order to work with survivors of trauma and implement appropriate interventions, disclosure about the traumatic event is essential in order to effectively treat the client (Chaudoir & Fisher, 2010; Egan, 1986; Jourard, 1964; Sorsoli, 2009). Taking into account the many factors that survivors must consider when deciding to disclose or discuss trauma, therapists may also consider a number of techniques that can be implemented to promote disclosure (Sorsoli, 2009) during intake and generally in the therapeutic relationship.

During the intake, the therapist can use an active approach to elicit participation. This approach might involve asking specific questions about the trauma verbally or in written form (e.g., assessment measures) and using non-verbal cues to find out additional information about the trauma, such as using supportive listening through nodding, eye contact, and leaning forward. This direct approach tends to promote more disclosure than the use of passive techniques (Josephson & Fong-Beyette, 1987; Kessler & Goff, 2006).

There are also three techniques that Bradley and Follingstad (2001) describe as separate categories of disclosure that may occur in therapeutic relationships and vary in their purpose. The first category, disclosure-through description involves the survivors recalling and recounting their memory of past traumatic experiences. The purpose of this type of disclosure is to avoid incomplete and inaccurate processing of the original trauma leading to later symptoms. The second category, disclosure-through-rethinking, includes the challenging of distorted thought processes and beliefs that are related to the trauma. The purpose is to correct any altered schemas about the self, world, and others that have arisen due to the traumatic event. Lastly, the disclosure-in-relationship category includes an examination of the individual's interpersonal relationships. The purpose is to focus on

the effect of the traumatic event on an individual's personal relationships. Any combination of the complex types of disclosure mentioned above can be used within the three processes of disclosure to create an experience that is comfortable and rewarding for the survivor. Both verbal and written discussion, as well as positive and negative discussion can be incorporated into disclosure-through-description, disclosure-through-rethinking, or disclosure-in-relationship during the sessions.

Throughout the disclosure or discussion, therapists must take into consideration the individual differences that the survivor may present with (discussed earlier). The styles (e.g., active or passive) and techniques of the therapist (e.g., focusing on disclosure-through-description, disclosure-through-rethinking, and/or disclosure-in-relationship) can be designed to match survivor characteristics (e.g., the presence of self-blame attributions, or cultural factors) and types of disclosure style (written or verbal, positive or negative, affective or cognitive). First, for example, those survivors who may be high in avoidance may benefit from positive expressive techniques, whether written or verbal, as they may facilitate a positive influence on disclosure by removing or attempting to reduce the shame and/or stigma associated with negative disclosures (Rieck et al., 2008). These techniques would fall under the category of disclosure-through-rethinking as the survivor is forced to rethink the event through a positive lens.

Second, disclosure-through-description, whether written or verbal may promote disclosure for those clients who are more expressive than other survivors (Bradley & Follingstad, 2001). Additionally, those who have experienced high amounts of invalidation in their lives may benefit from incorporating written expression of negative events versus verbal expression of negative emotional events in order to lessen any

anticipated invalidation by the listener, given the fact that written disclosures have less of a social component than do verbal disclosures (Sorsoli, 2009). The element of written expression in general may serve as a protective factor against avoidance of disclosure.

Lastly, the category of disclosure-in-relationship can help to promote and foster intimacy in relationships between the discloser and the listener. Therapists using this modality might support the survivor in using more affective versus cognitive/factual expressions of the traumatic event to promote disclosure and more intimate outcomes for the survivor (Chaudoir & Fisher, 2010).

In general, a person who is met with validating responses will be more likely to discuss the trauma again (Linehan, 1993), as many supportive, validating, social relationships help survivors of trauma make meaning of the trauma via a sense of togetherness (Rieck et al., 2005). More detail about responses and reactions to trauma disclosure and discussion is provided in the next section.

Responses and Reactions to Discussion/Disclosure of Trauma

There are a number of ways in which a person can respond to a survivor's traumatic disclosure. Historically, many researchers have focused on categorizing responses as either positive or negative. A main contributor in this field of research has been Marsha Linehan, who has enriched the field with a terminology describing the definitions of both positive and negative reactions. Linehan (1993) coined the terms *validating* and *invalidating* responses to describe the positive and negative responses to an individual's beliefs, thoughts, disclosures, or behaviors. This study will use these terms in regards to the specific area of disclosure responses. In recent years, attention has also been brought to a neutral or "no response" category (Pruitt & Zoellner, 2008). While

responses to disclosure can be categorized into positive, negative, and no-support reactions, the concept that these categories can simultaneously exist in a survivor's experience, and that they are influenced by the survivor's perceptions and history (Hong et al., 2011) should also be considered.

Research posits that the response to a survivor's discussion of trauma may be influential in trauma recovery (Brewin et al., 2000; Hong et al., 2011; Krause et al., 2003; Pruitt & Zoellner, 2008; Rieck et al., 2005; Shenk & Fruzzetti, 2011; Sorsoli, 2009). Therefore, reactions of therapists, those intending to aid the survivors in the healing process, are instrumental in the recovery process and must be carefully constructed. The major tenets of psychotherapeutic interventions for trauma tend to encompass the very characteristics of supportive, positive responses to traumatic discussion described by Linehan (1993), such as creating a strong therapeutic alliance, using empathy, a positive perspective and direct approach. Although it is known that these components are vital in psychotherapeutic interventions in working with discussions of trauma, graduate programs may lack specific trainings on working with traumatized clients during the training process. Therefore, it is important to explore how therapists in training may also respond to trauma discussions/disclosure.

Thus, this section first provides a full discussion of both positive and negative reactions by people in general (including therapists) to the discussion and disclosure of trauma, including categories and their definitions. Each subsection within this discussion is followed by the effects of the positive or negative responses on survivors. Second, this section describes the training provided to therapists regarding responding to trauma

disclosures and discussions, and research regarding responses specifically by therapists to trauma disclosure.

Positive responses. Research describing the characteristics of positive responses and the needs of survivors who are discussing trauma is minimal (Beutler & Hill, 1992). Based on the extant research (Beutler & Hill, 1992; Josephson & Fong-Beyette, 1987; Kessler & Goff, 2006; Linehan, 1993, 1997; Palmer et al., 2001), this dissertation placed positive responses into the following categories: validating responses, supportive responses, empathic responses, active/straightforward responses, and positive emotional/behavioral responses (each category is defined below). The survivor may be met with a single positive response type, or with a combination of positive response types (in any order) to classify the response as a positive response. Since there are no extant definitions of positive responses that are all-encompassing, for the purpose of this study, a positive response will be defined as a response to a disclosure or discussion of trauma that leaves the survivor feeling validated and supported by using empathy, active and straightforward responses, and/or a positive emotional and behavioral display.

Validating responses. Best described by Linehan (1997), a validating response is defined as occurring when a person expresses his or her own experience to another (e.g., trauma) and the response to the disclosure is that of understanding, legitimacy, and acceptance of the experience. Validation, in that sense, does not try to change the person's individual experience, though it does seek to facilitate the survivor's acceptance and experience of his or her emotions. Other components of a validating response can include the survivor's perception of legitimate understanding and acceptance of the experience by the listener (Josephson & Fong-Beyette, 1987; Linehan, 1993), which may

be passively or actively displayed or shared by the listener (Gable, Gongaza, & Strachman, 2006).

Supportive responses. Supportive responses contain certain characteristics that may differ slightly from validating responses. For example, a supportive response may be one that is encouraging (Josephson & Fong-Beyette, 1987). Survivors also describe supportive responses as those in which they feel cared for and feel safe and advocated for by the listener (Kessler & Goff, 2006). Being non-judgmental and positive as a way to empower the survivor are also ways to show support when responding to trauma discussions (Gable et al., 2006; Josephson & Fong-Beyette, 1987; Palmer et al., 2001).

Empathic responses. Jourard (1964) explained empathy to be the act of behaving as-if. He defined empathy as when one individual is able to imagine that he or she is the other person who has experienced the situation being discussed. Therefore, true empathy is when the listener is able to imagine herself as the other person (Jourard, 1964). In the context of trauma discussion and disclosure, the listener is able to imagine the experience as if he had the feelings, thoughts, and behaviors of the survivor. Empathic responses then, are those in which the listener conveys that she can relate to the survivor's thoughts and feelings during the discussion by imagining that she experienced the situation as the survivor (Palmer, et al., 2001).

Active and direct response style. Another component of positive responses is an active and straightforward response style in which the listener deals with feelings instead of avoiding them (Palmer et al., 2001), and acts in a knowledgeable manner in regards to the topic (Josephson & Fong-Beyette, 1987). The listener might also ask direct questions related to the traumatic experience, as research shows that survivors who have suffered

trauma tend to find an active, more direct approach more helpful than an indirect approach (Briere & Scott, 2012). Finding a direct and appropriately timed intervention can be key to a positive disclosure experience (Josephson & Fong-Beyette, 1987).

Appropriate emotional and behavioral responses. Finally, it is important that the listener use positive emotional and behavioral responses when receiving the discussion or disclosure of trauma, such as behaving in a way that conveys comfortability with the survivor and the material being presented, such as leaning forward when listening, making culturally-congruent eye contact with the survivor, and using an appropriate facial expressions, such as a face of understanding/concern while listening (Josephson & Fong-Beyette, 1987; Kessler & Goff, 2006). Reacting calmly and confidently and without anger are also positive emotional responses or reactions to the discussion or disclosure of trauma (Linehan, 1993).

Effects of positive responses on survivors. Past research posits that responses and reactions to the discussion of trauma can be impactful for an individual's prognosis; thus, positive reactions (versus negative) may have positive effects on a survivor (Brewin et al., 2000; Hong et al., 2011; Krause et al., 2003; Pruitt & Zoellner, 2008; Shenk & Fruzzetti, 2011; Rieck et al., 2005; Sorsoli, 2009). A survivor's traumatic disclosures and discussions can be empowering and increase his or her confidence about solving problems and managing situations in the future (Rieck et al., 2005). Individuals who experience a positive response to one disclosure or discussion of trauma are more likely to disclose again (Shenk & Fruzzetti, 2011). Furthermore, those who are consistently met with validating responses to their experiences and emotions throughout their lives, tend to exhibit less emotional dysregulation, and lower levels of psychological distress (Shenk &

Fruzzetti, 2011). Research also supports the idea that the disclosers of traumatic information, when sharing with close relationship partners (e.g., spouses, parents, best friends, roommates) tend to report feeling closer, more intimate, and more satisfied with their relationships, if met regularly with supportive responses such as understanding, validating, and feeling cared for (Gable et al., 2006). Thus, a positively perceived response to his or her discussion and/or disclosure of trauma is central to the individual's continual growth and healing posttrauma.

Individuals who experience such growth and healing after a traumatic event can be described as having experienced posttraumatic growth, a concept that is central to the positive psychology movement. As previously defined above, Tedeschi and Calhoun (1996, 2004) define posttraumatic growth as the development of a positive outlook following trauma, and describe that the individual may experience positive changes relating to others, new possibilities, personal strength, spiritual change, and a new appreciation for life.

More specifically, survivors who perceived positive reactions such as having the listener encourage them to talk more about the trauma, reacting calmly, with empathy, and with concern, felt relief and increased trust in the listener (Josephson & Fong-Beyette, 1987). These survivors also reported an increase in discussion and disclosure after receiving these positive reactions from their significant others (Josephson & Fong-Beyette, 1987). These positive interactions can lead to posttraumatic growth, as noted by Rieck et al. (2005).

Negative responses. A trauma survivor may be met with a negative response to his or her disclosure or discussion of the trauma, or with a neutral or no response while

discussing the trauma (Gable et al., 2006). This dissertation has used extant research to organize the types of negative responses into specific categories (Butler, 1978; Courtois & Watts, 1982; Josephson & Fong-Beyette, 1987; Lee et al., 1976; Linehan, 1993,1997; Pruitt & Zoellner, 2008). These categories include, invalidating responses, unsupportive responses, unempathetic responses, inactive/indirect responses, and inappropriate emotional/behavioral responses. The survivor may be met with any combination of these negative response types, or may be met with one individual negative response type. There are no existing definitions of negative responses that are all-encompassing, and consequently, for the purpose of this study, a negative response will be defined as a response to a disclosure or discussion of trauma that leaves the survivor feeling invalidated and unsupported by having a recipient who responds unempathetically, inactively and indirectly, and/or displays inappropriate emotions when responding.

Invalidating responses. Invalidating responses are best described by Linehan's (1993) definition. She defines an invalidating response as occurring when an individual communicates a private experience (e.g., trauma) and this disclosure is met by erratic, inappropriate, and extreme responses. At times, the experience may even be punished, trivialized, or ignored by the listener. This response can be confusing for survivors, as they may wonder if their own emotional responses are incorrect, socially unacceptable, or undesirable (Pruitt & Zoellner, 2008). Reacting with shock or disbelief may also be categorized as invalidating the survivor's experience (Butler, 1978; Courtois & Watts, 1982). Recent research has also included the concept of a no-support reaction as being invalidating to disclosure (Pruitt & Zoellner, 2008) since having the listener ignore the

information or react in an unresponsive way invalidates and denies the survivor's experience.

Linehan (1993) hypothesizes that invalidation can be broken down into two categories, general invalidation (GI) and specific invalidation (SI). Linehan defines general invalidation as a type of invalidation that may be experienced on a day-to-day basis, independent of childhood sexual abuse (CSA). Her definition of specific invalidation refers to the specific invalidation that may occur in regards to the disclosure of CSA, and refers to invalidation by the person to whom the abuse is being disclosed. For the purposes of this research these definitions will remain, but will not be specific to CSA and will include various types of trauma.

Hong et al. (2011) discussed two forms of specific invalidation: perceived and anticipated invalidation. As previously defined, perceived invalidation is considered to include anything that the discloser categorizes as invalidating. It may be influenced by the survivor's state of mind, current mood state, diagnosis or past history (Hong et al., 2011). It is the perception of the discussion or disclosure that may have a negative impact upon the survivor, even when the individual's perception may not be congruent with the actual response of the listener (Hong et al., 2011; Rieck et al., 2005). Likewise, anticipation of invalidation, which tends to arise among individuals who have been invalidated in the past, can lead to a heightened perception of negative responses to the discussion of trauma, as well as consequences such as avoiding discussion of the trauma in order to prevent the anticipated invalidation (Hong et al., 2011).

Unsupportive responses. Unsupportive responses tend to include those in which the respondent reacts with blame, or even outrage at the survivor (Courtois & Watts,

1982; Josephson & Fong-Beyette, 1987). While these reactions are seemingly easily identified as unsupportive responses, there are other unsupportive responses that may instead be confused as being empathic or supportive by the respondent. For example, many respondents may intend to respond in an empathic or understanding way by responding to the information with horror or outrage at the behaviors of the offenders or non-protective social supports of the survivor (Butler, 1978; Josephson & Fong-Beyette, 1987). However, research posits that responding in such a manner (where outrage is expressed), whether the outrage is aimed towards the survivor, the offender, or non-protective social supports, is often is a negative response, since the survivor may be left feeling unsupported, with possible negative feelings towards the respondent (Butler, 1978; Josephson & Fong-Beyette, 1987). One explanation for the negative feelings aimed at the respondent could be that the survivor may feel as if the listener has “missed the point” so to speak, regarding their feelings, or the listener’s bold display of feelings might take away from the survivor’s experience of his or her own feelings.

In addition, survivors report that perceiving the listener as hostile or aggressive is also unsupportive (Hong et al., 2011). Individuals who respond to discussions of trauma by acting bitter or in a disapproving manner will also be considered to be unsupportive (Hong et al., 2011). Being judgmental and not advocating for the survivor or empowering the survivor are also unsupportive responses (Josephson & Fong-Beyette, 1987).

Unempathetic responses. Another component of negative responses is an unempathetic response. Katz (1963) states that, “without empathizing with another, we tend to treat him as an ‘it’ rather than a ‘thou’” (p. 394). In an unempathetic response, the listener is unable to imagine him or herself as the survivor. Unempathetic responses

are those in which listeners do not convey that they are listening in an empathic way (Palmer et al., 2001). More specifically, they may display a judgmental tone when responding to the discussion or disclosure of trauma (Courtois & Watts, 1982). In addition, these listeners may lack warmth and affection or may be critical or demanding of the survivor (Hong et al., 2011).

Although empathy is something that most good listeners aim to embody, there are many discomforts of involving oneself empathetically with a survivor of trauma (Katz, 1963). Katz (1963) notes that it is understandable that listeners may be hesitant to offer more than superficial empathy, especially when confronted with difficult and traumatizing disclosures or discussions. Therefore, a listener may mean to respond empathetically, but may be unable to do so due to the dark nature of the disclosures or discussions.

Inactive and indirect response style. An inactive and indirect response style can also be classified as a negative response, in which the listener may dismiss the subject matter, minimize the effects or importance of the trauma, or even divert the topic and dismiss or avoid the survivor's feelings (Josephson & Fong-Beytte, 1987). An inactive and indirect response style can also be recognized in those listeners who state unfamiliarity with the topic, act without confidence in regards to the subject matter, and may give a neutral response without actively gathering further information (Pruitt & Zoellner, 2008). Survivors who experience their listeners to be indifferent or neglectful when discussing or disclosing the trauma would consider their listeners to be acting in an inactive and indirect response style. Survivors note this style to be associated with

listeners who seem disinterested and unconcerned with discussion of the traumatic material (Hong et al., 2011).

Inappropriate emotional and behavioral responses. Finally, inappropriate emotional and behavioral responses, such as a look or reaction expressing discomfort by the listener (Josephson & Fong-Beyette, 1987) or excessive interest in inappropriate areas of the trauma (i.e., sexual details) are considered negative responses to the disclosure/discussion of trauma. Leaning away from the survivor, avoiding eye contact (when not culturally congruent/appropriate), and reacting with an erratic or heightened emotional response (i.e., reacting frantically, with anger, rage, shock, horror) are also considered negative behavioral and emotional responses to the discussion and disclosure of trauma (Josephson & Fong-Beyette, 1987; Linehan, 1993). Many survivors report that being rushed or controlled during the disclosure/discussion were inappropriate responses by the listener (Palmer et al., 2001).

Effects of negative responses on survivors. Despite the many positive changes that may occur after the disclosure and discussion of a traumatic event described previously, research maintains the idea that in certain circumstances, a negative response to the disclosure or discussion of trauma could be damaging for the survivor (Rieck, et al., 2005). A negative response to a discussion of trauma may result in harming effects on the survivor as well as diagnostic implications.

Damaging effects may be more likely to occur with certain reactions to their disclosures and discussions of a traumatic event. Responses that can be harmful or detrimental to a survivor include instances where the respondent reacts with shock, horror, distress, blame or disbelief (Butler, 1978; Coutois & Watts, 1982; Josephson &

Fong-Beyette, 1987). Most notably, an invalidating response to disclosure can leave the survivor with feelings of confusion, wondering if his or her emotional response is incorrect, socially unacceptable or undesirable (Pruitt & Zoellner, 2008). Shenk and Fruzzetti (2011) assert that disclosing a traumatic event to an invalidating listener may actually contribute to problematic psychological outcomes.

It should also be noted that the effects of a negative response to the disclosure or discussion of trauma may be influenced by a number of factors. These factors likely impact how much of a problematic outcome is experienced by the survivor, as a result of the negative response/reaction. Some of these factors include the type of trauma being disclosed, and the time between the trauma and the disclosure (Chaudoir & Fisher, 2010; Deblinger et al., 2011; Hong et al., 2011; Ming Foyne, Freyd, & DePrince, 2009; McCormick, 2007; Rieck et al., 2008; Segal et al., 2009; Sorsoli, 2011; Ullman, 2007). For example, a negative response to a stigmatizing traumatic event such as child sexual abuse or rape, might create a more severe effect on a survivor than say someone who received an invalidating response in relation to surviving a wildfire or other natural disaster. Additionally, timing can be an influence on the level of problematic outcome experienced by the survivor. Research suggests that the survivor may naturally experience significant symptom reduction over time probably as a function of the innate self-healing process (Briere & Scott, 2012); therefore, the survivor may experience lower levels of problematic outcome in regards to potentially invalidating disclosures.

According to Linehan's model (1997), invalidation at its most extreme, is emotional abuse. Linehan bases this assumption on her biosocial model, which proposes that invalidating responses may lead to significant psychological problems as well as

problematic emotional responses and dysregulation (Krause et al., 2003). Physiological changes have also been documented to occur when an emotional disclosure is invalidated, including such changes as increased heart rate, and skin conductance over time (Shenk & Fruzzetti, 2011). Finally, individuals who experience large levels of invalidation throughout their lives tend to adopt a coping style where suppression or avoidance is used to regulate emotions (Shenk & Fruzzetti, 2011).

Disclosing a traumatic event to an invalidating listener may have serious diagnostic implications (Shenk & Fruzzetti, 2011). As previously mentioned, Pruitt and Zoellner (2008) found results that suggest that both the absence of positive social support (neutral reaction to disclosure) as well as negative social support (negative reaction to disclosure) act to remove resources that may be helpful to a survivor processing trauma. Both of the above types of invalidation are shown to lead to greater severity of Posttraumatic Stress Disorder (Zoellner et al., 1999). The detrimental effects that may stem from both types of invalidation are similar, though a neutral or non-supportive reaction to disclosure may have a later onset and have longer-term effects than those of a negative reaction, according to past research (Pruitt & Zoellner, 2008).

The many diagnoses that can result from traumatic events may have a higher probability of becoming present, or may be exacerbated by a negative response to the disclosure or discussion of trauma. Diagnoses such as depression, including complicated or traumatic grief, major depression, and/or psychotic depression, may be linked to traumatic events (Briere & Scott, 2006). Anxiety and stress disorders may also be a response to a traumatic event including diagnoses of generalized anxiety, panic, phobic anxiety, posttraumatic stress disorder, and/or acute stress disorder (Briere & Scott, 2006)

and can impact the perception of a negative response by the listener, as well as the level of severity of the individual's symptomology. Trauma may also result in diagnoses such as dissociative disorders, somatoform disorders (e.g., somatization disorder and conversion disorder), brief psychotic disorder with a marked stressor, and/or substance use or abuse disorders (Briere & Scott, 2006).

Trauma can also result in a higher prevalence of personality disorders, especially when the trauma is considered to be chronic in nature or identified as a disorder of extreme stress, not otherwise specified (DESNOS), otherwise known as complex trauma (Briere & Scott, 2006). When the level of trauma is chronic, interpersonal, and/or severe in nature, increased somatic and dissociative problems, including chronic difficulties in identity, boundaries, interpersonal skills, and affect regulation may increase or be present (Briere & Scott, 2012). For these individuals, the response to the discussion or disclosure of the traumatic event is especially important, as they may anticipate a negative response based on past experience, or based on their difficulties in identity, boundaries, interpersonal skills, and affect regulation. If met with a negative response, their symptoms may increase, causing them to decompensate quickly and impulsively due to their lack of affect regulation.

Many times these symptoms are characterized as Borderline Personality Disorder, and this diagnosis tends to be greater in individuals who have experienced high levels of constant and consistent invalidation, and those who have been multiply traumatized (Hong et al., 2011; Linehan, 1993, 1997). These individuals use avoidance and dissociation to regulate emotions as a result of the invalidating responses they received throughout their lives. While this type of chronic invalidation is different from that which

may be experienced in a therapeutic relationship, the characteristics of an individual with Borderline Personality Disorder may influence the survivor's perceived and anticipated invalidation levels throughout the therapeutic process, thus making it difficult to establish the main tenets of a positive psychotherapeutic relationship (Hong et al., 2011). The importance of the survivor's perception and anticipation about disclosing the information to other individuals should also be considered when examining this phenomenon (Rieck et al., 2008). Individuals who perceive a disclosure or discussion of their traumatic information as negative are also at risk for being harmed, though their perception may or may not be aligned with reality (Hong et al., 2011).

Therapists' responses to trauma discussions or disclosure. Many trauma survivors seek professional help to deal with their experiences, and research suggests that the reaction of the professional is critical to their recovery (Palmer et al., 2001). Training is valuable because it should prepare a professional to respond positively to clients' or patients' disclosure or discussion of trauma (Josephson & Fong-Beyette, 1987; Palmer et al., 2001). Findings from McGregor, Thomas, and Read (2006) suggest that in order to avoid making serious errors in therapy, therapists need to be trained in special skills to aid in their awareness of special dynamics in working with trauma, and to help with developing an open and strong therapeutic relationship that includes ongoing consultation. Without such specialized training, professionals are reported to react in both positive and negative ways to clients who disclose trauma (Josephson & Fong-Beyette, 1987; Palmer et al., 2001). Thus, this subsection provides a brief discussion about the history of professional training for therapists working with individuals who have

experienced traumas, followed by suggested therapist responses, as well as the effects of therapist's reactions to trauma disclosure.

Professional training. A number of studies have focused on the training and knowledge of professionals in regards to working with traumatized individuals (Josephson & Fong-Beyette, 1987; Martsolf, Draucker, Cook, Ross & Stidham, 2010; Palmer et al., 2001). Such professionals include educators, police, medical residents, emergency room personnel, and therapists (Martsolf et al., 2010; Palmer et al. 2001). Research has found that there tends to be a lack of generalized training in the area, and for those who do receive specialized training, a link between perceived lack of training and less comfort in working with trauma survivors abounds (Martsolf et al., 2010).

Regarding psychotherapists in particular, historically there was little formal professional trauma training given as part of the general curricula to trainee therapists (Feldman-Summers & Pope, 1994; Gold, 1997). Many graduate programs continue to lack any introductory efforts to familiarize trainees with specific trainings on working with traumatized clients (Gold, 1997; Gold & Brown, 1997), leading to inexperienced and uninformed therapists working with traumatized individuals. While these therapists may mean well, their efforts may be potentially harmful to the client (Courtois, 2008; Gold, 1997). In 1996, the American Psychological Association (APA) highlighted the need for specific training and curricula development in the area of family violence and other forms of trauma (Gold, 1997).

After APA's suggestion in 1996, there have been a number of training methods proposed in order to train therapists to work with traumatized individuals (Brack, Brack, & Infante, 1995; Courtois, 1988; Courtois & Gold, 2009; Dolan, 1991; Gold, 1997;

Herman, 1997; Kessler & Goff, 2006; Koenig et al., 2004; McCarthy, 1990; Palmer et al., 2001). For example, Gold (1997) delineated how to adequately prepare trainee therapists to provide services to trauma victims, specifically those who are victims of CSA in three phases. Gold describes that Phase 1 consists of symptom identification and amelioration, Phase 2 consists of confronting and processing trauma in an active and directive manner, and Phase 3 consists of the integration and consolidation of adaptive functioning for clients. This model highlights the components of positive responses described earlier and works in conjunction with additional training methods. These methods can be applied to most any training program for trauma work, cross theoretical assumptions, and include assigned readings, group supervision and staffing, individual supervision, and process meetings. These training procedures tend to result in the highest level of trained professional as they provide an all-encompassing model for training, including a haven of supportive outlets through supervision (Gold, 1997). Despite the existence of such programs, Courtois and Gold (2009) continue to highlight the disparity between the need for professional services by those with expertise in psychological trauma, and the lack of availability for training in the area. While some institutions are mandating trauma courses within their curriculum, and educational resources are widely available (e.g., <http://psycnet.apa.org/journals/tra/3/3/235/>; <http://www.apatraumadivision.org/resources.php>), implementation of trauma training as part of the mandated curriculum has yet to be decided on a national level.

Suggested therapist responses. Though there is little training for therapists regarding how to respond to clients who discuss trauma in session, there is some literature that suggests what clients and evidence based treatment programs suggest to be

the best or most preferable implementations. For example, direct encouragement to discuss and re-process thoughts and feelings surrounding stressful and traumatic experiences has been shown to promote posttraumatic growth by aiding in decreasing stress levels, reducing the impact of intrusive thoughts, improving mood, enhancing emotional regulation and feelings of control, improving resilience, facilitating meaning making and identity development, and improving overall individual psychological and physical functioning (Hemenover, 2003, Lutgenorf & Antoni, 1999; Pennebaker et al., 1988; Pennebaker, 1997, Tedeschi & Calhoun, 2013). This subsection briefly describes research related to suggested therapist reactions, and ends with ways to implement these suggestions.

A training manual from the Auckland Training Programme in New Zealand described both problems with current responding, as well as a proposal for how therapists should respond to clients who experienced and discussed sexual abuse in session (Read et al., 2007). The manual highlighted how mental health professionals tend to ask and inquire very little about trauma and respond in a way that offers low levels of information or support. Some of the barriers to correct inquiry and appropriate response discussed in this manual included the therapist tending to other, more immediate needs and concerns; concerns about offending or distressing clients; fear of vicarious traumatization; and fear of inducing ‘false memories’ or the client being male, more than 60 years old, or having a diagnosis of psychosis. Facilitating factors to these barriers included lack of training in how to ask about and respond to trauma, and the clinician being male or the opposite gender of the client.

In response to these observations, the Read et al. (2007) team came up with eight principles of responding to abuse disclosures:

1) Affirm that it was a good thing to tell; 2) do not try to gather all the details; 3) ask if the person has told anyone before-and how it went; 4) offer support (make sure you know what is available as far as resources); 5) ask whether the client relates the abuse to their current difficulties; 6) check current safety-from ongoing abuse; 7) check emotional state at the end of session; 8) offer follow-up/‘check-in.’ (p. 106)

Read et al. (2007) highlighted validation as a main component of how to successfully respond to clients who have disclosed sexual abuse. Specific recommendations included validating and acknowledging the client’s difficulties in talking about the trauma as well as encouraging them that it was a good thing to tell, for example, “In my experience, people often find that, although it’s difficult, it can often be really helpful to talk about it. How is it for you talking about this now?” (Read et al., 2007, p. 107). Additionally, another suggestion was to avoid trying to gather all the details. The brief manual noted, “it is not necessary, or desirable, on first being told by a client that they have been abused to immediately gather all the details. This can all come later if the person chooses to discuss it (Read et al., 2007, p. 107).” They point out that, “clinicians may feel under pressure to gather all the details, or try to fix the ‘problem’ immediately, or both” (Read et al., 2007, p. 107) when facing decisions about how to respond to trauma discussion (p. 107). Research also notes the importance of offering support, and checking in about client’s emotional state after the session (Read et al., 2001).

Reasons for an emphasis on affective/emotional connection versus fact gathering are likely linked to other research that highlights the importance of a client's affective experience and the therapeutic alliance with the therapist when discussions of trauma occur. The client's emotional experience, whether positive or negative, as related to the trauma tends to influence the client's recovery process (Lutgendorf & Antoni, 1999). Specifically, research posits that being able to give a detailed disclosure of thoughts and feelings surrounding the trauma appears to be effective in enhancing self-regulation and feelings of control of the situation (Hemenover, 2003). Additionally, Palmer et al. (2001) noted that survivors of trauma who had sought professional help for their trauma rated that being able to deal with their feelings was the second most helpful approach by their mental health professional, and empowering/feeling in control as another helpful approach in feeling comfortable and helped in therapy.

In addition, when treating trauma, some theories suggest that the therapist's job is not only to inquire about and process discussion of emotions, but also to help clients to regulate their emotional state, allowing them only to disclose as much as would keep them regulated at one time to avoid retraumatization in session (Bicknell-Hentges & Lynch, 2009; Palmer et al., 2001; Read et al., 2007). Based on the model by Briere and Scott (2006), which discusses the different levels of intensity of emotional stimulation that individuals who have experienced complex trauma might experience while discussing their traumas, Bicknell-Hentges and Lynch (2009) gave recommendations for regulating the clients' intensity in sessions. One recommendation, typically used when clients are stuck in Level One (lowest intensity) would be to ask affective based questions about how the client was feeling when the specific event occurred (e.g., How were you

feeling when...?). Similarly, they noted that counselors can decrease the client's emotional intensity when it is at a higher level, or to help keep a client at a Level One (lowest intensity), by asking content based questions not specifically related to the trauma (e.g., How old were you at the time?). Therefore, this model highlights that the thoughtful use of such content-based questions can be an asset in trauma treatment, which can facilitate client growth and healing via either means. The beneficial use of this model utilizes thoughtful insight by the therapist about the client's emotional state, how much intensity a client might be able to handle, and utilizing both affect or content driven questions with appropriate timing and thoughtful purpose.

As a way to guide the session, research suggests collaboration can help to decrease assumptions of control by the therapist and to increase feelings of a positive therapeutic alliance for trauma survivors. Utilizing open-ended questions is one way to elicit more control from clients (Palmer et al., 2001), as they provide more space for clients to explore what they feel comfortable sharing, without putting limitations or bounds on the discussion. Additionally, using listening skills (Palmer et al., 2001) rather than feeling a need to do or say something can help to foster a collaborative environment. Research notes that over-utilizing questions can create assumptions of control or give the impression that the therapist is asking such questions to clarify, prior to providing a definitive answer/solution (Weiner & Bornstein, 2009). This overutilization might send a message that does not support collaborative work, where the client has control, which previous trauma literature notes as important to survivors (Palmer et al., 2001).

Finally, reflections, both complex and simple, tend to have a vital place in establishing a strong therapeutic relationship, allowing the client to feel understood and

heard, and creating opportunities for therapists to make sure they understand what their clients are saying. In Miller and Rollnick (2012)'s MI Terms glossary, simple reflections are defined as, "Reflections that contain little or no additional content beyond what the client said" (p. 11); whereas complex reflections are defined as "An interviewer reflection that adds additional or different meaning beyond what the client has just said; a guess as to what the client may have meant" (p. 3). Complex reflections require more skill and practice by therapists, and create the experience of being more deeply understood and accepted by the counselor (Miller & Rollnick, 2012). Additionally, they note that reflections serve as a gateway to empathy, since once the therapist can truly understand what the client is thinking, feeling, or doing, then the therapist potentially will have a greater ability to be empathic.

Effects of therapist reactions. Extant research with professional level therapists and other professional services who deal with traumatized individuals suggests that their reactions to the client's disclosure can affect the relationship between the professional and the survivor, as well as the survivor's own feelings towards the disclosure process and trauma in general (Weaver, Varvaro, Connors, & Regan-Kubinski, 1994). For example, positive reactions, such as reacting calmly with sensitivity and empathy, can lead to a healthy therapeutic alliance, survivor empowerment, and posttraumatic growth (Josephson & Fong-Beyette, 1987; Weaver et al., 1994). Negative responses or reactions by the professional may convey negative emotions and feelings to the survivor, which could be reminiscent of the trauma itself (Weaver et al., 1994). These feelings may include betrayal, stigmatization, and powerlessness, which can ultimately damage the relationship between professional and survivor, as well as delay healing for the survivor.

In regards to how neutral responses might affect clients, research suggests that neutral or no-response categories can be as unproductive and potentially harmful for survivors as negative responses (Shenk & Fruzzetti, 2011). Research notes that the detrimental effects that may stem from neutral or no-response reactions may have a later onset than negative responses, but might have longer-term effects than those of negative responses (Pruitt & Zoellner, 2008). Additionally, the absence of positive support, in the form of neutral responses, acts both to remove resources that may be helpful to a survivor of trauma, and might lead to greater severity of PTSD (Pruitt & Zoellner, 2008; Zoellner et al., 1999). This subsection briefly describes research related to the three types of responses and their outcomes, and ends with therapist characteristics that may influence outcomes.

Survivors themselves, both male and female, report that some of the most important features in a positive disclosure process include a safe and strong therapeutic relationship, a direct approach through psychoeducation or being transparent about the therapeutic process, and an active style in which straightforward questioning and a willingness to ask the specific questions that are needing to be asked (Draucker & Petrov, 1997; Farber, Berano, & Capobianco, 2004; Josephson & Fong-Beyette, 1987; Palmer et al., 2001). Additionally, clients identified positive reactions of the therapist to include availability, sensitivity, being nonjudgmental, supportive, competent, being able to give clear information, and validating the individual's experience (Martsolf et al., 2010). Those who encouraged their clients to talk about the trauma and who reacted with empathy and concern also helped to foster positive outcomes in their clients (Josephson & Fong-Beyette, 1987; Palmer et al., 2001).

Positive outcomes for clients who experienced the above reactions from therapists or helping professionals included increased positive behaviors and decreases in negative self-harm behavior, increased spontaneous coping abilities and decreased denial of problems, ability to function at an increased level occupationally and socially, decreases in depression, anxiety, guilt, and other undesired emotions, and increased levels self-esteem (Martsolf et al., 2010). Additionally, these individuals tended to be more likely to disclose or discuss the trauma outside of therapy as well and felt an increased sense of relief, both physical and emotional after working with the professional (Farber et al., 2004; Josephson & Fong-Beyette).

Clients' reports of negative reactions or responses to their disclosures or discussions of trauma included such things as therapists' perceived discomfort with the topic, minimizing of the effects or importance of the trauma, excessive interest in inappropriate areas of the trauma (i.e., sexual details), rushing clients, and anger directed at clients or offenders (Josephson & Fong-Beyette, 1987; Martsolf et al., 2010).

Additionally, clients reported negative reactions to include blaming or not believing the client, ignoring the abuse history, and not listening, as well as feeling that a professional is judgmental, aloof, or is rushing or pushing the client or who gives overwhelming information (Martsolf et al., 2010).

Clients who perceived therapists and professionals as having a negative reaction reported a lack of trust in them and stopped therapy or treatment after disclosure and were less likely to disclose or discuss the trauma again (Josephson & Fong-Beyette, 1987). Feelings of powerlessness and feeling demeaned were also reported by clients who experienced negative reactions (Martsolf et al., 2010).

While research suggests neutral or “no-response” categories to be as harmful as negative responses in some cases, examples of these “no-response” categories exist in the literature. For example in a study measuring whether clinicians take action or not when a male client discloses childhood sexual abuse (via self-report survey of British mental health staff), 5% of nurses, 10% of psychologists and 24% of psychiatrists said they take no action (Lab, Feigenbaum, & De Silva, 2000). Conversely, simple reflections might actually reflect understanding and acceptance of a client (Miller & Rollnick, 2012).

One might speculate that such pressure to respond in a neutral way may stem from a number of factors such as: novice therapists being more comfortable with gathering information versus emotional material, issues surrounding the client-therapist alliance, and/or the therapist-participant’s own characteristics (e.g., possible past trauma, uncomfortability with the topics, being nervous or anxious about not saying anything, wanting to gather details to fully understand, focusing on cognitive facts to avoid client becoming affectively dysregulated or upset, fear of the client losing control or not being able to handle talking about the trauma). Extant literature does cite potential barriers for therapists inquiring about and responding appropriately to trauma discussion, such as the therapist being focused on other more immediate needs and concerns, therapists having concerns about offending or distressing clients, fear of vicarious traumatization, or fear of the clinician inducing “false memories” (Read et al., 2007, p 107). Additionally, within the trauma literature, there is a common experience of clients with PTSD fearing they may lose control or lose their minds (Foa, Hembree & Rothbaum, 2007). While there is no literature regarding therapists’ particular feelings about their clients having such

experiences in session, this extant client-focused literature might also be relevant when thinking about clinicians' fears of exploring painful emotional material with clients.

Finally, research indicates that in addition to the therapist's or professional's level of training and his or her actual response to the discussion of trauma, there may be certain therapist characteristics that have the ability to influence the client's perception about the disclosure process (Courtois & Watts, 1982). Such factors include the sex of the therapist, the survivor's past experiences with disclosure and/or discussion, and the therapists own attitudes and assumptions about trauma (Briere & Scott, 2012). For example, if a client experienced a trauma at the hands of a male, having a male therapist may impact the survivor negatively as the client may be less likely to trust the therapist. Also, if the survivor has only had negative responses in the past when disclosing trauma, she likely will anticipate and perceive a negative response for future disclosures (if they occur at all). Lastly, if the therapist has him/herself experienced a traumatic experience in his/her past, or has certain religious or political beliefs that impact his views on traumatic events and the survivors, then it is likely that the survivor will pick up on these and include them in their analysis of the reaction, possibly perceiving it negatively.

Purpose of Study and Research Questions

Overall, research suggests that during discussions of trauma in therapy, the responses and reactions of the listener can have a powerful impact on the trajectory for the survivor of the trauma. In other words, positive responses to traumatic disclosure/discussion can positively influence an individual, and negative or neutral responses to traumatic disclosure/discussion can negatively influence an individual. Regarding therapy, there are certain common psychotherapeutic interventions that have

been found to be effective when used with survivors of trauma, which include the therapeutic alliance, empathy, and using both a strengths-based approach and a direct approach with survivors. Despite these findings, there appears to be a lack of training and research on how trainee therapists respond to a client's disclosure or discussion of trauma during sessions. Extant research that includes client input in regards to positive and negative response characteristics among therapeutic relationships indicates specific factors to be of importance when responding to traumatic disclosure. As a result, this study sought to explore trainee therapist responses to the discussion of trauma in therapy. Accordingly, this study conducted a qualitative analysis of trainee therapist reactions/responses to the discussion/disclosure of trauma. The specific research question was as follows: How do trainee therapists respond to the discussion of trauma in therapy?

Chapter II. Method

The present study utilized a qualitative analysis to observe how trainee-therapists responded to trauma discussion in five transcribed sessions. This chapter describes the research design and rationale, participants, data collection, coding, and analysis procedures.

Research Design

As was done in the current study, qualitative inquiry is commonly used in clinical and counseling psychology research as it tends to mirror the models and methods used in clinical practice, and can be used to answer “How” or “What” questions rather than “Why” questions (Mertens, 2009; Morrow, 2007). Additionally, it is also appropriately used when there is inadequate research on the question of interest and/or existing theories do not fully explain the question being explored, as qualitative research is able to provide a more in-depth analysis of the research question in the context being examined (Creswell, 2009; Mertens, 2009; Morrow, 2007). Furthermore, qualitative research is useful for exploring and understanding how individuals or groups make meaning out of a certain situation (Creswell, 2009; Glazer & Stein, 2010).

For the purpose of this research, a clinical research design, developed with the aim of assisting researchers in observing the clinical context was used (Mertens, 2009) to investigate trainee therapists’ responses to the discussion of trauma in therapy sessions. More specifically, a treatment process approach, allowing for the naming, describing, classifying, and counting of the behavior of the therapist was used in this study (Stiles, Honos-Webb, & Knobloch, 1999). The approach specifies a variety of categories, specifically

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

Stiles et al. (1999) also recommends that the topic being investigated will influence the choice in measure that is used in the treatment process approach on a case by case basis, as in the current study.

It should be noted that during the treatment process approach, chosen categories can be applied, leading to the researcher observing directly through case studies or analyses of brief segments; or, more typically, measures can be aggregated across a stretch of treatment (Stiles et al., 1999). Therefore, the frequency of a category in each session, or the average of a rating across a whole treatment may be described (Stiles et al., 1999). Descriptions regarding the application of the treatment process approach for this particular study, including chosen derived categories, and how they were applied and reported is provided in the Data Analysis Approach section.

Participants

Participant cases. Purposeful sampling was used to identify and examine five psychotherapy cases from a Southern California University's community counseling center's archival databases of videotaped sessions. First, the researcher sought approval by the Institutional Review Board (IRB) of her university. In order to be included in the study, both client-participants and therapist-participants had to meet various inclusion and exclusion criteria that had been previously decided. Additionally, 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 were unavailable and could not be identified.

To be included, in the study, potential participants had to be at least 18 years of age at intake and be English-speaking. Written consent also had to be obtained for both written and videotaped materials by both the participant and the therapist in order to be included in the research database. Cases had to also include "sufficient" data, meaning that their records, which consisted of video recordings of psychotherapy sessions, and a written Telephone Intake Summary, Client Information Adult Form, Intake Evaluation

Summary, and Treatment Summary (see Procedure section), contained information that signified that the client had experienced trauma (as previously defined). Finally, participants must also have had at least one videotaped session in which they discussed a traumatic event, and therapists must be trainee therapists (masters-level or doctoral-level students).

There were two exclusion criteria for the present study. First, the researchers were not allowed to be personally familiar with the therapist-participant and/or client-participant in order to maintain confidentiality and reduce potential researcher bias during the coding process. Second, only adult participants who were receiving individual (versus couples or family) therapy were included in the sample. There were no exclusion criteria based on gender, socioeconomic status, race/ethnicity, or religiosity. The client-participant information was stored and organized via a participant tracking sheet (see Appendix F). Table 1 provides a summary of the demographic information for each of the client-participants.

Table 1

Client-Participant Demographic Information

C-P	Age	Gender	Ethnicity	Traumatic Event	DSM-IV-TR Diagnoses
1	28	Female	African-American	Child Sexual Abuse	Partner-Relational Problem
2	47	Female	European-American	Stroke/Blindness	No Diagnoses
3	21	Female	El-Salvadorian	Child Phys/Sexual Abuse	MDD; R/O PTSD; BPD

(continued)

C-P	Age	Gender	Ethnicity	Traumatic Event	DSM-IV-TR Diagnoses
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

Researcher-participants. The researcher-participants for this study consisted of a team of three clinical psychology doctoral students who coded the collected data (Coders 1, 2, and 3). A clinical psychologist served as the auditor for the study and supervised the research team throughout the data collection, coding, and analysis process. The inclusion of multiple researchers and an auditor provided the opportunity for an array of diverse perspectives, helped to minimize individual biases, and helped to sufficiently capture the complex nature of the data (Hill, Thompson, & Williams, 1997). The following is a personal description (e.g., background, professional views) provided by each of the coders and auditor in an effort to identify potential areas of bias.

Coder 1, the primary researcher and dissertation author, is a 27-year-old, Caucasian, female clinical psychology doctoral student. She was born and raised in a middle-class family in the northeastern part of the United States. Coder 1 was reared with a Christian background and considers her faith and spirituality to be an important part of

her daily life. Coder 1 generally conceptualizes and treats clients, from an integrative perspective, including relational, positive psychology, and cognitive-behavioral techniques. More specifically, she believes that dysfunctional or maladaptive thinking, in combination with human interaction, and a strengths-based approach, can strongly influence how an individual thinks about and interprets situations. Accordingly, 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 1 also views the therapeutic relationship and a sense of authenticity as necessary elements upon which such change can occur.

Additionally, Coder 1 believes that a positive reaction to a discussion of trauma, when expressed in a genuine and benevolent manner, has the 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 1 is particularly interested in the current reactions to disclosure of trauma among trainee therapists.

Coder 2 is a 29-year-old Caucasian, female, doctoral student in clinical psychology. She was raised in the northeastern part of the United States in a working class family. Coder 2 does not prescribe to a particular religious background. In her work with clients, Coder 2 has found faith-based interventions to be particularly useful with clients who identify strongly with religion/spirituality and rely on it as a coping tool. Coder 2 primarily conceptualizes and treats clients from a cognitive-behavioral approach,

although she incorporates strengths-based approaches in her work with clients. Coder 2 views and values the interaction between thoughts, feelings and behaviors as highly significant in the human experiences and believes that strengths-based approaches are vital to keep an ethical and strong working relationship between the client and therapist. As it pertains to this dissertation, Coder 2 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 how trainee therapists respond to discussions of trauma in therapy.

Coder 3 is a 28-year-old Caucasian female doctoral student in clinical psychology. She was raised in a middle class home in the western United States. She considers spirituality an important component of life. In general, 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. Moreover, she believes that the reaction of the therapist to the discussion of trauma has the capacity to strongly influence the therapeutic relationship, which she considers paramount in working with clients who have experienced such severe hardships.

The auditor for this study is also the dissertation chair. She is a Christian, European-American, married female with a doctoral degree in psychology in addition to

a terminal law degree. She is a tenured, associate professor of clinical psychology with research and clinical interest in positive and forensic psychology. She conceptualizes clients primarily from a cognitive-behavioral perspective, although she also incorporates systems and strength-based approaches into her treatment. Accordingly, she believes that the response of the therapist can assist individuals who have experienced trauma, including those who share such experiences in psychotherapy, in examining their experiences from different perspectives, which in some cases can lead to resilience and growth. She also is curious as to how therapists in the proposed study will respond to clients' trauma discussions, and anticipates a range of responses.

Instrumentation

In order to examine reactions of trainee therapists to the discussion of trauma in psychotherapy sessions, the primary researcher created a deductive coding system for the classification of therapist-participant behavior from an in-depth review and analysis of the literature. The coding system consisted originally of two main categories of therapist responses to a client's statement: a positive response (POS) or a negative response (NEG). However, after preliminary pilot coding, a third category was created to capture neutral responses (NEU) as well as the addition of two forms of adjunctive coding to track missed opportunities for positive responses (+), as well as the use of clinical data by trainee therapists (*).

In the literature, the original two main categories each contained five subcategories, resulting in ten total classification categories. The five categories for positive responses included validating, supportive, and empathic responses, active and direct response styles, and appropriate emotional and behavioral responses, while the five

categories for negative responses included invalidating, unsupportive and unempathetic responses, inactive and indirect response styles, and inappropriate emotional and behavioral responses. Given the limitations of this study, such as being unable to reliably measure certain subcategories (e.g., observational methods alone could not capture the therapist-participant's internal process), and operationally define discrete codes for overlapping categories, only three subcategories of the five existing subcategories were included in each of the two main categories: *positive responses*, which included validating, supportive, and empathic responses within it; and *negative responses*, which included invalidating, unsupportive, and unempathetic responses within it.

Additionally, since there was little information in the literature about neutral responses, other than the fact that they tend to have a negative impact on the survivor, neutral responses were originally proposed to be included in the negative subcategory. However, during pilot coding for the current study, examples of other types of neutral responses were found. These were separated into subcodes based on the types of responses found, including clarifying questions, and reflection/summary statements. Additionally, adjunctive codes that accounted for missed opportunities for therapists to respond positively, and the use of clinical terminology during the response were added as the final codes. The entire transcripts were coded, and then separated out based on trauma discussion sections and non trauma discussion sections. The codes are discussed and operationally defined next.

Positive responses (POS1, POS2, POS3). This positive category was created based on the extant research on reactions and responses to traumatic disclosure by Beutler and Hill (1992), Briere and Scott (2006), Gable, Gonzaga and Strachman (2006),

Josephson and Fong-Beyette (1987), Kessler and Goff (2006), Linehan (1993; 1997) and Palmer et al. (2001) regarding the most effective positive responses to traumatic disclosure, as noted by trauma survivors, therapy clients, and therapists. The positive category was broken down into three separate subcategories that comprise positive reactions when discussing trauma both in therapy and in personal relationships, and for the purposes of this research, include responses that are validating, supportive and/or empathic. Each is defined next.

Validating responses (POS1). Coded as POS1, validating responses included instances of the therapist-participant displaying Linehan's (1997) definition of validation; when a person expresses his or her own traumatic experience to another and the response to the disclosure conveys understanding and/or acceptance of the thoughts, feelings and behaviors related to the traumatic experience. Examples of POS1 included statements that suggested explicit understanding such as "I understand how someone would be upset by that," or acceptance "what you went through was difficult." Additionally, validation in the form of a reflection was also included. The term "complex reflection" from the Motivational Interviewing literature was used to help clarify the specific types of reflections that were the most validating, including responses by the therapist that either reflected the inferred meaning of a statement, or reflected feeling through paraphrasing, ultimately focusing on the emotional aspect of the statement. Both forms of complex reflections add new meaning to the client's statement, showing deeper understanding and acceptance (Miller & Rollnick, 2012). The use of implicit expressions of validation such as "mmhmm," or "I see" were not included, as such commonly used statements are considered regulators or backchannel cues (Ferrara, 1994).

Supportive responses (POS2). Responses that were considered to be supportive were classified into code POS2 and included responses described by Josephson and Fong-Beyette (1987), Kessler and Goff (2006), Gable, Gonzaga and Strachman (2006), Briere and Scott (2006) and Palmer et al. (2001) as encouraging, those that advocated for the client, and those that empowered the client. Examples of these in the coding manual included encouraging, “I’m glad you’re talking about this,” “Go on,” “Tell me more,” and/or advocacy/empowerment, “You deserve to be at peace with this,” “You are very strong for having gotten through this.”

Empathic responses (POS3). As described by Jourard (1964) and Palmer et al. (2001), *empathic responses (POS3)* were those in which the participant-therapist verbalized how she was able to imagine that she was the other person who has experienced the situation being discussed. In other words, the participant-therapist displayed that she could engage in the experience as if she had the feelings, thoughts and behaviors of the survivor. POS3 was deemed to only include therapist-participant verbalizations that utilized “I statements” to help coders identify expressions related to personal disclosures by the therapist-participant that indicate possible feelings of the survivor (e.g., “I would have been very afraid”), thoughts of the survivor (e.g., “I would have been thinking the worst in that situation”), or behaviors of the survivor (e.g., “I would have wanted to run away”).

Negative responses (NEG1, NEG2, NEG3). This negative response category was created based on the extant research on reactions and responses to traumatic disclosure and was gathered from research by Butler (1978), Courois and Watts (1982), Josephson and Fong-Beyette (1987), Lee et al. (1976), Linehan (1993,1997), and Pruitt

and Zoellner (2008) regarding the most common negative responses to traumatic disclosure, as noted by trauma survivors, therapy clients, and therapists. Three separate subcategories found to be classified as negative reactions when discussing trauma both in therapy and in personal relationships are discussed and for the purposes of this research, include those that are invalidating, unsupportive and/or unempathetic. Each is defined next.

Invalidating responses (NEG1). Responses there were considered to be invalidated were coded using NEG1 and included instances of the therapist-participant displaying a modification of Linehan's (1993) definition of invalidation: when an individual communicates a traumatic experience and this disclosure is met with an inappropriate, punishing, trivializing, or judgmental response, and/or meets the disclosure with a dismissive response. Example codes of inappropriate responding in the coding manual included, "Oh wow, I've never worked with someone who has had such trauma", punishing/trivializing/judgmental example responses included "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 example responses in the coding manual included "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.

Unsupportive responses (NEG2). Responses that were considered unsupportive were coded as NEG2 and included responses in which the person exhibited disbelief over the traumatic event (e.g., "Did that really happen to you?", "That seems impossible," or "Are you sure it happened the way you're remembering it?"), or belittled the client (e.g.,

“You could have been such a better person if this didn’t happen to you” or “You may never get over this”). Other examples of NEG2 in the coding manual included the therapist reacting with outrage or horror at the survivor (e.g., the therapist gasps aloud when they are told the information), offender (e.g., “I am so angry with the person who did that to you!”), or non-protective social supports of the survivor (e.g., “How could your parents let this happen!? They are clearly unfit parents!”; Butler, 1978; Courtois & Watts, 1982; Josephson & Fong-Beyette, 1987, Hong et al., 2011).

Unempathic responses (NEG3). Katz (1963) describes these responses to be somewhat common during discussions of traumatic material. He noted that while therapists may mean to respond empathically, they may be unable to do so given the difficult content of the discussion. Courtois and Watts (1982), Palmer et al. (2001), and Hong et al. (2011) discussed unempathetic responses to include instances in which the listener is unable to imagine him or herself as the survivor. Unempathetic responses are those in which listeners do not convey that they are listening in an empathic way (Palmer et al., 2001). For the purpose of this study, unempathic responses included instances in which the listener was distracted while the client was speaking, was demanding of, or pushed expectations on the survivor. These listeners may lack warmth and affection while being distracted, (e.g., “What were you saying? I’m having a hard time paying attention”), or may be demanding of the survivor (e.g., “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,” or “You really need to face the perpetrator of this right away”; Hong et al., 2011).

Neutral responses (NEU1, NEU2). The neutral response category was created after the preliminary pilot coding. Neutral or “no responses” categories were originally partially accounted for by the NEG1 category in the negative section, given the research noting that these types of responses could be as potentially damaging for survivors as negative reactions (Pruitt & Zoellner, 2008; Shenk & Fruzzetti, 2011). Separating, redefining, and adding subcategories to a neutral response coding section were decided on after the preliminary / pilot coding exercise, where each of the coders noticed and agreed on seen trends. The neutral categories were teased out to include two separate subcategories, *Clarifying Questions* (NEU1), and *Reflection/Summary Statements* (NEU2), each are discussed next.

Clarifying questions (NEU1). Responses that were classified as clarifying questions were coded as NEU1 included instances of the therapist-participant asking questions (not statements as in POS1) to gather information or facts regarding the content of the traumatic event or about the client’s affective experience. An example in the coding manual included, “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 summary statements (NEU2). Similarly to the NEU1 code, the inclusion of *Reflection/Summary Statements* (NEU2) occurred after the original literature review, during the coding process. This category included the therapist participant using “simple” reflective or summary statements that directly and concretely repeated back the content or affective experiences of the events that occurred in the client’s recollection of the traumatic event or experience (Miller & Rollnick, 2012). To be considered a

reflective NEU2 response, the therapist participant could either simply repeat one or more aspects of what was said, change one or more of the words used in a statement, but could not add any new meaning. Examples in the coding manual included, “C: And I now become startled whenever I hear a loud noise” T:” Hearing loud noises is startling/frightening for you” The client’s language had to often or always be used by the therapist when making such a statement, and the therapist had to stop at the reflection without delving further into suggested meanings of the statements to convey understanding/acceptance of the client’s feelings/thoughts/behaviors, as in POS1. The distinction between Validating Responses (POS1) and NEU2 was teased out by looking to the Motivational Interviewing literature regarding simple versus complex reflections. Complex Reflections as defined above in POS1, were grouped into that category because they require more skill and practice on the end of the therapist, and create the experience of being more deeply understood and accepted by the counselor.

The second part of the NEU2 code consisted of opportunities the therapist-participants used to summarize the client’s statements. Again, definitions were found in the MI literature that explained summaries as “special types of reflections” in which a counselor uses periodically to review what the client has discusses so far, recognizing the problem, the client’s concerns and optimism for change. Examples of summaries in the coding manual included, “So when you were in Afghanistan, you experienced XYZ within two months of arrival,” or “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...”

Adjunctive codes. Also included after preliminary / pilot coding were two adjunctive codes that could be added either in addition to a main POS/NEG/NEU code

described above, or could be used alone. Missed opportunities (+) included instances in which there was a clear opportunity that therapist could have utilized a positive response, (e.g., therapist changes the subject after client attempts to talk about or process trauma, or the therapist focuses strictly on content after client expresses affect). Additionally Clinical responses (*) were used in instances in which the therapist-participant used clinical terminology or psychoeducation when speaking to the client about the traumatic event or presentation (e.g., recovery, symptom presentation, or treatment). Facilitative statements were considered to be included, (e.g., “mmhmm,” “yea,” “ok,” “right”), but ultimately were not included in this coding process, as there was little information surrounding how the facilitative statement would be received by the client given the lack of the coders ability to interview the client, and/or gather knowledge about the therapist’s body language, tone, and intonation when using the facilitative statement to infer how they meant the response.

Procedure

Sample selection. Purposive sampling was used in the study based on general guidelines to choose participants who met the research criteria (Creswell, 1998; Mertens, 2009). The steps created in the preliminary proposal were used, in part. A list of pre-screened cases with transcribed sessions (those used in former PARC research teams) were reviewed by the coders of this study to determine whether the cases met criteria for the study inclusion (see Step 1 of coding manual). Once it was decided that all five of the pre-screened cases met inclusion for the present study, Steps 2-4 were not completed.

Coding. The three researcher-participants described earlier served as the primary coders for the study as explained above. Practice coding was completed by the coders

prior to coding the chosen sessions, and a goal of 66% agreement was kept (two of three coders, or the highest possible rate short of unanimous). Extant literature in the field suggests an 80% agreement to be appropriate for a study of this kind (Miles & Huberman, 1994), however given there were three coders, 66% was the highest possible match to the literature. Training in relevant concepts and specific coding processes as related to the current study were completed by all coders. After consensus by the coders was reached on codes, the codes were audited by their research/dissertation supervisor, with a goal of reaching 75% agreement (three of four coders in agreement).

Human subjects/ethical considerations. A main goal of this research study was to protect the rights of the therapist and client participants, and to maintain ethical standards and confidentiality by using non-invasive methodology (i.e., an archival database). Furthermore, the researchers in the current study aimed to maintain a high standard of ethical practices, including reviewing informed consent forms (see Appendix G) and making sure that all client and therapist participants in the study consented to written, audio, and video materials for the inclusion criteria noted above. The files and materials included in the database were only created once therapy was terminated and each file was given a unique research identification code, and was redacted, and de-identified by research assistants to ensure confidentiality for all participants during the data collection process.

Additionally, each researcher, coder, and transcriber involved in the present study completed IRB and HIPAA certification courses online (see Appendix I). Confidentiality was protected via written agreements to ensure that any data was kept confidential. Lastly, steps were taken by researchers and research assistants to ensure that there were

no dual relationships between the researcher participants and client participants (i.e., that the coders did not have personal relationships with any of the clients or therapists used in the study).

Data Analysis

This study utilized a clinical research design, developed with the intent of assisting researchers in observing the clinical context to better understand a problem (Mertens, 2009). The data analysis approach used tends to be used with qualitative research and is naturalistic in nature (Hsieh & Shannon, 2005). In order to take into account current theories, narrow down the research question and develop an initial set of codes to be used in studies, a deductive analysis was used. Such analyses help to “validate or extend conceptually a theoretical framework or theory” (Hsieh & Shannon, 2005, p. 1281). As applied to the present study, an extensive review of the literature was surveyed and synthesized in order to identify key types of responses to trauma discussion, and other related concepts to create the initial coding categories and operational definitions used to observe trainee therapist responses to trauma discussion.

The coders in the study also regularly discussed any potential or actual biases or conflicts of interest that arose during the coding process. Research highlights that one’s demographic differences or differences in theoretical orientation may impact the way a particular coder views the transcripts, which might then affect the way she codes a particular response (Ahern, 1999). In order to correct for this, each coder kept both a reflective journal and a combined audit trail of the results, in order to record any biases or inconsistencies that came up throughout the process (Lincoln & Guba, 1985). Discussions were had on a weekly basis to compare the coding, as well as to provide

these results and discussions via audit trail to their auditor for guidance. The auditor then reviewed the potential differences in coding and actively communicated with the coders to ensure reliability on the final decision for each code.

The section below contains steps, as suggested by Stiles et al. (1999), which outline and delineate the specific elements of analysis for the present study. Specifically, this study analyzed therapists' [target of measurement] verbally communicated responses to TD [channel of communication] 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. Researcher-participants in the present study read through the previously transcribed session transcripts and independently highlighted any text that by first impression, appeared to qualify as a positive, negative, neutral or adjunctive response by a trainee therapist. Transcript material included mostly verbal information, and some transcripts included nonverbal behaviors observed subjectively by research assistants who wrote down their opinions on what they saw in the video tape as they transcribed (e.g., gestures, sighs, yawns, body movements, laughs, smiles, and occasionally tone).

Step 2: Coding selected text. After the highlighted transcripts were shared with each coder, each researcher reviewed the highlighted portions and assigned relevant codes to each area of highlighted text (see Instrumentation section for detailed description of codes). Each rater independently coded their responses in separate *Microsoft Word* documents that contained the transcript information, highlighted material, and three columns, one for each rater. Separate documents created in the same program were created to track notes, questions for the group, coding rationale, and process commentary. If text that had been highlighted was determined as not fitting any of the existing coding categories, it was left out. As recommended in the literature by Hsieh and Shannon (2005), the researchers made consistent efforts to identify and analyze additional recurring themes to determine whether further coding categories or subcategories were needed. As noted above, neutral and adjunctive categories and subcategories had been added during the preliminary pilot coding session, but no new codes were further identified when coding transcripts 1-5.

The researcher-participants (coders 1, 2, and 3) all examined the data independently before comparing codes, discussing rationale for choices, and coming to consensus on codes disagreed on. Hill et al. (1997) asserted that such a use of multiple researchers can be beneficial as it allows for diverse perspectives and opinions, better captures complexity of the data, and minimizes individual biases. While discussing codes that were not in 100% agreement, at least one of the coders typically changed her coding given the input, feedback, and rationale from the other coders. Typically this occurred when coding POS1 versus POS2 (as validation and support were sometimes confused) or when coding NEU1 versus NEU2. Given the nature of the NEU codes, it was typical that

one researcher might have labeled questions as NEU2, confusing the labels for the category they actually meant. This mistake was particularly noteworthy in the sessions that were coded earlier on, as all three coders were getting used to one another's codes and were more apt to get confused or code differently. Over the course of discussing the codes in disagreement and hearing others' rationales for codes, the team generally reached consensus and became more familiar with the codes. Perfect agreement was not expected, nor was it a goal of the discussions, rather the purpose of such discussions was to assist each coder in making an informed decision that was most accurate given the coding system.

When coding did not reach 100% consensus after the discussions, each coder documented her rationale for the decisions made, so that the auditor would have insight into the coders' judgment processes and rationales (Orwin, 1994). The auditor was then given each person's rationale and the codes in question before adding to the discussion and coming to a cohesive final decision. The auditor's decision and decision making process were recorded in the audit trail and re-presented to the team. The team then discussed the updates and ultimately decided the final code. There were both pre and postcoding sets of codes, which included the independently developed codes prior to consulting with the team, as well as the codes that were later 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 the raters to whom she compared them; Harris & Lahey, 1982).

Any potential individual biases that might have influenced the coders while they were independently coding, or discussing the codes were discussed as well. Some biases

were seen across coders when trying to decipher whether the code was positive or negative in nature. Given the content of some of the sessions and ideas of how a therapist *should* be responding, there were some instances in which a coder applied a negative code to the response, when others applied a positive or neutral code. These biases tended to be based on the session material, the coders' personal feelings, and their views as professionals and trainee therapists. After a discussion of such biases, coders made every attempt to correct them when coding future sessions, and to point them out to one another, to ensure consistency across sessions and codes.

Fleiss' Kappa coefficient (K ; Fleiss, 1971) was used to calculate interrater reliability among researcher participants both for the initial coding impressions, as well as for the final, agreed upon codes. These results are summarized in Tables 2 and 3 below. The Fleiss' Kappa coefficient attempts 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). This measure is appropriate for assessing reliability for a fixed number of raters and nominal-scale ratings, as in this study. Unlike Cohen's Kappa, Fleiss's Kappa has the ability to assess reliability among more than two raters (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 seen in Table 2 below, the average Fleiss' Kappa score for codes in this study prior to the team meeting to discuss the codes, ranged from (0.94) to (.542) According to Landis and Koch's (1997) guidelines for interpreting inter-rater reliability, Kappa scores indicate that the team was in agreement near perfectly for NEU1 codes, in substantial agreement for NEU2, POS1, POS3, Clinical, and NEG2 codes, and in moderate agreement for POS2, NEG3, NEG1, and Missed Opportunity codes. All codes appeared in and were coded across the five transcripts. Table 2 below provides a summary of the average rates of agreement for codes prior to meeting to discuss the codes:

Table 2

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

	Session 1	Session 2	Session 3	Session 4	Session 5	Avg
POS1						
Fleiss' Kappa	0.753	0.522	0.871	0.599	0.953	0.74
Observed Agreement	0.989	0.926	0.978	0.906	0.996	0.958
Expected Agreement	0.955	0.845	0.832	0.765	0.905	0.858
POS2						
Fleiss' Kappa	0.823	0.411	0.853	0.473	0.914	0.6
Observed Agreement	0.994	0.954	0.971	0.949	0.996	0.971
Expected Agreement	0.964	0.922	0.804	0.903	0.948	0.908
POS3						
Fleiss' Kappa	N/A	0.606	N/A	0.830	0.953	0.716
Observed Agreement	1	0.982	1	0.993	0.957	0.983
Expected Agreement	1	0.955	1	0.765	0.905	0.98
NEG1						
Fleiss' Kappa	0.876	0.449	0.331	0.381	0.598	0.526
Observed Agreement	0.994	0.975	0.995	0.938	0.996	0.977
Expected Agreement	0.949	0.955	0.993	0.900	0.989	0.955
NEG2						
Fleiss' Kappa	0.899	0.661	0.749	-0.004	1	0.66
Observed Agreement	0.998	0.989	0.998	0.993	1	0.995

(continued)

	Session 1	Session 2	Session 3	Session 4	Session 5	Avg
NEG2						
Expected Agreement	0.984	0.969	0.990	0.993	0.987	0.983
NEG3						
Fleiss' Kappa	1	-0.007	1	-0.004	1	0.598
Observed Agreement	1	0.986	1	0.993	1	1.195
Expected Agreement	0.995	0.986	0.986	0.993	0.987	0.989
NEU1						
Fleiss' Kappa	0.968	0.905	0.960	0.917	0.971	0.94
Observed Agreement	0.995	0.965	0.981	0.971	0.993	0.978
Expected Agreement	0.848	0.630	0.516	0.687	0.766	0.689
NEU2						
Fleiss' Kappa	0.706	0.574	0.968	0.563	0.942	0.75
Observed Agreement	0.984	0.968	0.995	0.902	0.996	0.968
Expected Agreement	0.946	0.925	0.850	0.776	0.923	0.881
MISSED OPP						
Fleiss' Kappa	N/A	-0.005	0.664	0.404	0.660	0.542
Observed Agreement	1	0.989	0.995	0.975	0.987	0.988
Expected Agreement	1	0.989	0.986	0.957	0.961	0.978
CLINICAL						
Fleiss' Kappa	0.622	0.566	0.856	0.621	0.748	0.68
Observed Agreement	0.995	0.989	0.998	0.971	0.996	0.989
Expected Agreement	0.987	0.976	0.983	0.923	0.982	0.97

Note. This table depicts average inter-rater reliability scores for each of the applied codes across sessions using Fleiss's 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 coding was completed independently, the inter-rater reliability in the above tables was calculated. The researchers discussed the codes as a group to reach consensus regarding the final codes before submitting their findings to the auditor of the study for final review.

Step 3: Submission of codes to auditor. All codes, whether in full agreement or still undecided, were submitted to the auditor for review and approval. Along with the codes, the researcher participants submitted an *audit trail*, a running document that held meticulous descriptions of the research and coding processes, clearly outlining the

individual and collective coding decisions, thought processes, rationales and actual transcribed discussions that had taken place for each coder, and between coders. Research suggests that using such a document is recommended (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 positive versus negative responses); 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. Additionally, specific potential biases of the coders will be discussed in the discussion section under limitations, but it should be noted that overall, any biases that came up were considered by the coders and discussed.

Step 4: Reaching consensus on final codes. The auditor checked and provided feedback on the research coding teams' decisions and rationale for codes. The coders and auditor continuously discussed and revised the final codes through ongoing communication on the audit trail document. Prior to obtaining a final consensus for the codes, the team would jointly discuss the codes, and comment on the auditor's insight and discussion as well. One example of this occurred in Transcript 3, T98 where the team had coded the following statement, NEU1: "Did it feel uncomfortable that you couldn't cry? Like did you feel like you needed to release that and you couldn't? Or it just felt like you were just feeling sad and you, it just didn't happen?" However, when the code was reviewed by the auditor it was pointed out that the statement might also be pushing expectations, but she noted that NEU1 could also be appropriate. The coding team reviewed the auditor's comments, discussed why they had originally coded NEU1, discussed how the code might have a negative flare, and what to do. Eventually the team decided that NEU1 fit best, this was reported to the auditor, who agreed.

After completing this process with any codes that had been originally in disagreement, and/or codes that the auditor pointed out during the process, consensus was agreed to on each of the 663 codes. 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 of the process described above. As such, the following values of Fleiss' Kappa represent a collaborative effort of the coders, in order to determining the final coding decisions. As depicted in Table 3, the average Fleiss' Kappa score for each of the 10 codes (POS1, POS2, POS3, NEG1, NEG2, NEG3, NEU1,

NEU2, MissedOpp, and Clinical) post-discussion were in the perfect agreement range ($K=1$). As discussed previously, no codes were unused throughout the process.

Table 3

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

	Session 1	Session 2	Session 3	Session 4	Session 5	Avg
POS1						
Fleiss' Kappa	1	1	1	1	1	1
Observed Agreement	1	1	1	1	1	1
Expected Agreement	0.949	0.881	0.854	0.765	0.887	0.863
POS2						
Fleiss' Kappa	1	1	1	1	1	1
Observed Agreement	1	1	1	1	1	1
Expected Agreement	0.981	0.909	0.885	0.907	0.954	0.925
POS3						
Fleiss' Kappa	N/A	1	N/A	1	1	1
Observed Agreement	1	1	1	1	1	1
Expected Agreement	1	0.969	1	0.957	0.987	.98
NEG1						
Fleiss' Kappa	1	1	1	1	1	1
Observed Agreement	1	1	1	1	1	1
Expected Agreement	0.935	0.919	0.979	0.841	0.967	0.92
NEG2						
Fleiss' Kappa	1	1	1	1	1	1
Observed Agreement	1	1	1	1	1	1
Expected Agreement	0.981	0.979	0.986	0.989	.993	0.98
NEG3						
Fleiss' Kappa	1	1	1	1	1	1
Observed Agreement	1	1	1	1	1	1
Expected Agreement	0.972	0.819	0.898	0.968	0.987	0.926
NEU1						
Fleiss' Kappa	1	1	1	1	1	1
Observed Agreement	1	1	1	1	1	1
Expected Agreement	0.850	0.692	0.523	0.720	0.774	0.7
NEU2						
Fleiss' Kappa	1	1	1	1	1	1
Observed Agreement	1	1	1	1	1	1
Expected Agreement	0.944	0.929	0.825	0.789	0.923	0.881

(continued)

	Session 1	Session 2	Session 3	Session 4	Session 5	Avg
MISSED OPP						
Fleiss' Kappa	1	1	1	1	1	1
Observed Agreement	1	1	1	1	1	1
Expected Agreement	0.944	0.845	0.958	0.869	0.905	0.9
CLINICAL						
Fleiss' Kappa	1	1	1	1	1	1
Observed Agreement	1	1	1	1	1	1
Expected Agreement	0.953	0.956	0.986	0.907	0.987	0.95

Note. This table 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. Both during the coding process and after the coding process was completed, the researcher reviewed the data and tracked frequencies of different forms of responses by trainee therapists. This process began with the researcher calculating frequencies for each code within and across each full session, and tracking them using *Microsoft Excel* spreadsheets. Trauma discussion bounds were decided as a team, and the process of organizing codes that fell within and outside the trauma discussion sections occurred during the evaluation as well. Each of these, TDSs and NTDSs were evaluated both within each session and across all five sessions. Data was further examined for any patterns (e.g., positive vs. negative vs. neutral response frequencies, types of responses overall vs. trauma and non trauma discussion sections) that existed within the sessions, as well as across the sessions, while paying mind to variables that may have contributed to the findings (e.g., type of trauma, type of session, therapist/client demographic characteristics).

Step 6: Presentation of findings. The following two chapters describe in detail the findings from this study. Frequencies of coded verbalizations along with contextual

factors are presented and explored along with an analysis that includes therapist responses to trauma versus non trauma discussion in psychotherapy sessions. Furthermore, additional patterns both within and outside of the codes for this study are discussed. The chapters below present sample quotations to provide a richer understanding of the manner in which trainee therapists responded to clients who have experienced trauma.

Chapter III. Results

This chapter presents the results of the qualitative content analysis of trainee therapists' responses to clients who have experienced trauma. More specifically the purpose of the analysis was to explore how trainee therapists responded to these clients' trauma discussions by observing how the trainee therapist responded when a client was discussing or disclosing to the therapist the traumatic event as compared to when they were discussing other matters during five psychotherapy sessions.

In order to gather this information, a coding system was developed by this researcher based on the extant literature (see methods section and coding manual for further descriptions and operational definitions) to categorize types of therapist responses in three main categories: (a) Positive Responses (POS), (b) Negative Responses (NEG), and (c) Neutral Responses (NEU). More specific subcodes were created to further identify therapist responses: In the Positive Responses category, (a) validating responses (POS1), (b), supportive responses (POS2), and (c), empathic responses (POS3); In the Negative Responses category, (d) invalidating responses (NEG1), (e) unsupportive responses (NEG2), and (f) unempathetic responses (NEG3); and in the Neutral Responses category (g) clarifying questions (NEU1), and (h) summary/reflection statements (NEU2). To obtain a comprehensive representation of the data, codes were analyzed across three types of discussion; first analyzed in relation to the full psychotherapy session (fully coded session, FCS), then coded sections of the transcript that were identified as the trauma discussion (trauma discussion sections, TDS) were differentiated from and compared with sections identified as the non-trauma discussion (non trauma discussion sections, NTDS).

The following chapter reviews the findings of the directed content analysis through presentation of both across and within-session results. The section denoting findings across sessions begins with overall code frequencies across sessions, then discusses trauma discussion code frequencies across sessions versus non trauma discussion code frequencies across sessions. A further breakdown of code frequencies across response type categories (e.g., positive, negative, neutral, etc.) and across discussion types (FCS, TDS, NTDS) follows. Coding frequencies are first presented to organize and categorize the data, and later, specifically in the section which synthesizes the coded results across sessions/participants, findings and examples of coded therapist responses are offered in order to illustrate the findings. All quotations were taken from the video-recorded psychotherapy session transcripts that were selected and used for this study.

Overall Code Frequency Across Sessions

The completed content analysis of trainee therapist responses in transcribed psychotherapy sessions with trauma survivors generated a total of 663 codes within 1,370 total therapist talk turns across all five transcripts, each in their entirety. This means that trainee therapists responded to clients in a way that was able to be coded 48% of the time. The sessions ranged from 184 to 418 therapist-participant talk turns, with a mean of 274 ($SD = 95.92$). Within each session, the total number of codes ranged anywhere from 103 to 203 codes, with a mean of 132.6 ($SD = 41.12$).

The 663 overall codes, agreed upon by the researcher participants (coders), were applied from three main categories of responses (a) positive responses ($n = 144$, 21.71% of all coded talk turns); (b) negative responses ($n = 101$, 15.23% of all coded talk turns),

and (c) neutral responses ($n = 328$, 49.46% of all coded talk turns); and from two additional codes that captured adjunctive data that was gathered (i.e., missed opportunities for therapists to incorporate a positive response ($n = 63$, 9.5% of all coded talk turns), and clinical responses that incorporated clinically relevant vernacular or questions ($n = 27$, 4.1% of all coded talk turns). Table 4 provides an overall summary of the percentages of categories among the coded responses across the overall transcripts (1-5).

Table 4

Overall Summary of Coded Frequencies and Percentages Across Fully Coded Sessions

	POS 1-5	NEG 1-5	NEU 1-5	Missed Opp 1-5	Clinical 1-5	Total Codes
Total codes	144	101	328	63	27	663
% of coded responses	21.71%	15.23%	49.46%	9.5%	4.1%	100%

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

Additionally, as the study aims to look at therapist responses to trauma discussion or disclosure, the sections of the transcript containing such trauma discussion were separated out from sections that did not contain trauma within the overall transcripts. The sections of the overall sessions that included trauma discussions/disclosures with trauma survivors generated a total of 469 codes within 701 total therapist talk turns. This means that trainee therapists responded to clients in a way that was able to be coded 67.1% of the time when trauma was being discussed. The trauma discussion sections ranged from 109 to 178 therapist-participant talk turns, with a mean of 139.8 ($SD = 29.56$). Within

each session, the total number of codes in the trauma discussion sections ranged anywhere from 36 to 153 codes, with a mean of 93.8 ($SD = 44.57$).

Across all five transcripts, there were 669 talk turns that met criteria for non trauma discussion. During non trauma discussion sections (NTDS), therapist-participants responded in a way that met criteria for coding a total of 194 times. This means that trainee therapists responded to clients in a way that was able to be coded 29% of the time when trauma was not being discussed. Non trauma discussion sections across transcripts ranged from 30 talk turns to 309 talk turns ($m = 133.8$, $SD = 108.62$). Within each session, the total number of codes in the non trauma discussion sections ranged anywhere from 4 to 71 per session ($m = 38.8$, $SD = 24.57$).

Additionally, when compared directly to the full session codes (663), trauma discussion codes (469) comprised 70.74% of the total coded responses. In other words, 29.26% of the coded responses occurred during non-trauma discussions (194). Table 5 highlights and summarizes the above information. A breakdown of the specific data can be found in Table 5 below.

Table 5

Overall Coding, Talk-Turn Frequencies and Percentages Across Sessions by Discussion Type

Full Session (FCS)	Session 1	Session 2	Session3	Session 4	Session 5	Total
Total Codes	107	116	203	134	103	663
Total # Talk Turns	418	189	278	184	301	1,370
% of coded responses	25.60%	61.37%	73.02%	72.83%	34.22%	48.39%

(continued)

Trauma Discussion (TDS)	Session 1	Session 2	Session3	Session 4	Session 5	Total
Total Codes	36	112	153	101	67	469
Total # TDS Talk Turns	109	159	178	113	142	701
% of coded responses	33.03%	70.44%	85.95%	89.38%	47.18%	66.90%

Non-Trauma Discussion (NTDS)	Session 1	Session 2	Session3	Session 4	Session 5	Total
Total Codes	71	4	50	33	36	194
Total # NTDS Talk Turns	309	30	100	71	159	669
% of coded responses	22.98%	13.33%	50%	46.48%	22.64%	28.99%

Overall Frequency Patterns Across Sessions

Neutral responses comprised 49.46% of all codes (30.10% of TD; 17.49% of NTD); positive responses were the next most frequent coded responses at 21.71% (18% of TD; 5.23% of NTD); and negative were the least common code at 15.23% (11.27% of TD; 3.29% of NTD). The pattern of distribution regarding neutral, positive, and negative responses existed across full sessions, and trauma versus non trauma discussion sections alike, in the same order of frequency noted above. When reviewing the general frequencies of positive, negative and neutral codes within each individual FCS session, the patterns within sessions were dissimilar when comparing the transcripts to one another. Findings included patterns of neutral responses being the most coded response within each session (T1 = 43%; T2 = 37.07%; T3 = 67% ; T4 = 38.8%; T5 = 49.57%), but then positive responses being the next most common (and negative responses being the least common) across session 3 (POS = 19.21%; NEG = 9.85%), session 4 (POS =

29.10%; NEG = 14.93%), and session 5 (POS = 26.21%; NEG = 7.77%); while negative responses were the second most frequent code (with positive responses being the least frequent) in session 1 (NEG = 27.78%; POS = 13.89%) and session 2 (NEG = 25%; POS = 2.69%).

Within individual sessions focused on trauma discussion sections (TDS), the pattern seen was again different from that of the overall across sessions' pattern (neutral, positive, negative); and was similar to the individual FCS patterns in that each session or transcript differed slightly, even within the TDS. For example within sessions, similar to results discussed above, neutral responses were again the most common response across all TDS (T1 = 36.11%; T2 = 36.61%; T3 = 52.80%; T5 = 50.75%), with the exception of session 4's TDS. As in the FCS results, trauma discussion sections of sessions 3 and 5 remained having positive responses as their second most frequent coded response and negative as the least frequent (T3, POS = 19.64%, NEG 19.1%; T5, POS = 23.88%, NEG = 5.97%), and TDS in sessions 1 and 2 also remained the same, with the second most frequently coded responses being negative responses, and least frequent, positive (T1, NEG = 22.43%, POS = 14%; T2, NEG = 25.89%, POS = 19.64%). In the TDS, session 4's progression of most commonly coded category to least commonly coded category changed from the FCS results, in that the session 4 TDS had more positive responses than neutral, changing the progression to positive category as highest frequency (31.68%), neutral in a close second (28.71%), and last being negative (16.83%).

Responses in non trauma discussion sections occurred in a pattern of neutral, positive, negative (T3, NEU = 84%, POS = 10%, NEG = 2%; T4, NEU = 30.30%, POS = 21.21%, NEG = 09.09%; T5, NEU 47.22%, POS = 30.55%, NEG = 11.11%), similar to

that of the overall across session's pattern, for all sessions except sessions 1 and 2. Session 1's frequency distribution for NTDS represented 46.48% neutral, 19.71% negative, and 14.08% positive, the same pattern distribution that occurred in both the FCS and TDS. Session 2 only had 4 codes across NTDS, creating a 50/50 split between neutral and positive responses (2 codes each).

Response Type Categories Across Sessions

The total number of responses by therapist-participants across all five sessions presented above included data from three main categories of responses: positive responses, negative responses, and neutral responses. The following section includes a specific analysis of the frequency of these main categories across discussion type (FCS, TDS, NTDS). The results are presented verbally and via tables 4-9.

Neutral codes. Responses of the neutral type were the most common across all five sessions, when looking at the whole coded sessions, the specific trauma discussion sections, and non-trauma discussion sections. The total number of neutral coded expressions ($n = 328$) ranged from 43 to 136 within each full session, with a mean of 65.6 ($SD = 39.53$). In other words, neutral responses occurred in 24% of all therapist-participant talk turns and comprised 49.47% of all codes in the fully coded session. These responses are broken down by section as well, with 211 neutral responses in the trauma discussion sections ($m = 42.2$; $SD = 30.74$), ranging from 13 to 94; and 117 neutral responses in non trauma discussion sections ($m = 23.4$; $SD = 15.31$), ranging from 2 to 42 per transcript. In other words, codes from the neutral category occurred 30.10% of the time across all trauma discussion talk turns (coded and non), while 45% of codes were classified as neutral in nature across trauma discussion sections. Therapist-participants

responded in a neutral way 17.49% of the time in non trauma discussions (when looking at total talk turns) and neutral responses comprised 64.29% of the total coded responses in non trauma discussion sections.

The neutral category was comprised of two separate types of responses by trainee therapist-participants. Of the 328 total neutral codes found across the five sessions, 249 (76%) of those were categorized as being *Clarifying Questions* (NEU1), while 79 (24%) were categorized as falling into *Reflection/Summary* statements (NEU2). Among trauma discussions specifically, the distribution was similar. Of the 211 neutral codes found across trauma discussions (TDS), 156 (74%) were classified as *Clarifying Questions* (NEU1), and 55 (26%) were classified as *Reflection/Summary* statements (NEU2). Among non-TDS, 117 neutral codes were found, 93 (79.49%) of which were *Clarifying Questions* (NEU1), and 24 (20.51%) were *Reflection/Summary* statements (NEU2).

Positive codes. The positive category of responses tended to be the second most common response type across all five sessions both when looking at whole coded sessions, and the specific trauma discussion sections. These responses ranged from 15 to 39 within each full session, with a total of 144 positive responses and a mean of 28.8 ($SD = 10.31$); ranged from 5 to 34 across trauma discussion sections, with a total of 109 positive responses ($m = 21.8$; $SD = 11.92$); and ranged from 2 to 11 across non trauma discussion ($m = 7$; $SD = 3.67$). In other words, positive responses occurred in 10.51% of all therapist talk turns, and made up 21.72% codes across the fully coded sessions (FCS). Positive responses also occurred in 18% of all trauma discussion talk turns, and comprised 23% of the coded responses across trauma discussion sections. Therapist-participants responded in a neutral way 5.23% of the time in non trauma discussions

(when looking at total talk turns) and neutral responses made up 19.23% of the codes across non trauma discussion sections.

The positive category was comprised of three separate types of responses possible for trainee therapist-participants. Of the 144 total positive codes found across the five sessions, 88 (61%) of those were categorized as being *Validating Responses* (POS1), 47 (33%) were categorized as falling into *Supportive Responses* (POS2), and only 9 (6%) were categorized as *Empathic Responses* (POS3). Among trauma discussions specifically, the distribution was again similar. There were 109 positive codes found across trauma discussions, 68 (62.4%) of those were classified as *Validating Responses* (POS1), 34 (31.2%) were classified as *Supportive Responses* (POS2), and only 7 (6.4%) were classified as *Empathic Responses* (POS3). Across non trauma discussion sections, there were 35 total positive codes; 22 (62.85%) classified as *Validating Responses* (POS1), 13 (37.14%) as *Supportive Responses* (POS2), and 2 (5.71%) as *Empathic Responses* (POS3).

Negative codes. Negative responses were the least common type of response across all five sessions, across full sessions, and across sections of trauma discussion, and non trauma discussion sections. They ranged from 8 to 29 with a mean of 20.2 ($SD = 7.76$) within full sessions, from 4 to 29 ($m = 15.8$; $SD = 9.47$) across trauma discussions, and from 0 to 14 with a mean of 4.4 ($SD = 5.59$) across non-TDS. In other words, negative responses occurred in 7% of all therapist-participant talk turns, 11.27% of all trauma discussion, and 3.29% of non trauma discussion. Negative responses made up 15.23% of all codes in the fully coded sessions, 16.8% of the codes in the trauma discussion section, and 11.34% of codes in the non trauma discussion sections.

Comprised of three separate types of responses possible for trainee therapist-participants, the presence of negative codes was distributed similarly between full sessions, trauma discussion only, and non trauma discussion. Of the 101 total negative codes found across the five sessions, 46 (45.5%) of those were categorized as being *Invalidating Responses* (NEG1), 45 (44.5%) were categorized as falling into *Unempathetic Responses* (NEG3), while 10 (10%) were categorized as *Unsupportive Responses* (NEG2). The same distribution was found when looking at non trauma discussion sections, in that 14 (63.63%) of the codes were *Invalidating Responses* (NEG1), 6 of the codes (27.27%) were categorized as *Unempathetic Responses* (NEG3), and only 2 responses (9.10%) were categorized as *Unsupportive Responses* (NEG2). Slight differences were found between the full sessions/non trauma discussion sections and trauma discussions specifically, such that of the 79 negative codes found across trauma discussions, the majority of which (39 codes or 49.4%) were coded as *Unempathetic Responses* (NEG3) and the next most frequent responses (32 codes or 40.5%) were categorized as being *Invalidating Responses* (NEG1). As with the full sessions, *Unsupportive Responses* (NEG2) were the least frequent responses; only 8 across trauma discussions, making up 10.1%, of negative responses and twice across non trauma discussion sections (9.1% of negative NTDS responses). In sum, while full sessions and non trauma discussion sections had *Invalidating Responses* (NEG1) as the most common negative code, trauma discussion sections had higher rates of *Unempathetic Responses* (NEG3) than *Invalidating Responses*. All had *Unsupportive Responses* (NEG2) as the least common negative code.

Adjunctive codes. As an addition to the main codes above, adjunctive codes were included. These codes accounted for clear missed opportunities to incorporate a positive response (i.e., missed opportunity), and documenting talk-turns that included clinical data (e.g., diagnostic assessments, psychoeducation about psychological illnesses, symptom clarification).

Responses with missed opportunities ranged from 6 to 16 across full sessions, with a total of 63 coded missed opportunities and a mean of 12.6 ($SD = 3.97$), ranged from 3 to 16 among trauma discussion sections with a total of 50 codes ($m = 10$, $SD = 5.7$), and ranged from 0 to 9 ($m = 2.6$, $SD = 3.78$) in the non trauma discussion sections. These responses occurred in 4.5% of the total session talk turns, 8.5% of all trauma discussion talk turns, and 1.94% of non trauma discussion talk turns. Missed opportunities accounted for 9.5% of codes across all sessions, 10.7% of codes across trauma discussion sections, and 6.7% across non trauma discussion sections.

Responses including clinical data ranged from 2 to 10 across full sessions, with a total of 27 codes including clinical information ($m = 5.4$; $SD = 3.85$), occurred 20 times in trauma discussion sections, ranging anywhere from 1 to 9 across sessions ($m = 4$; $SD = 3.32$), and occurred 8 times in non trauma discussion sections, ranging anywhere from 0 to 5 responses ($m = 1.4$, $SD = 2.07$). These responses comprised 2% of the total talk turns across full sessions (4.07% of codes), 2.85% of all talk turns in the trauma discussion sections (4.26% of codes), and 1.04% of the non trauma discussion talk turns (3.6% of codes). The frequency of each code described above, within and across sessions for the whole session (see Table 6), trauma discussion sections (see Table 7), and Non trauma discussion sections (see Table 8) are summarized in the tables below.

Table 6

*Frequency Data for Therapist-Participant Responses Within and Across Sessions-
WHOLE SESSION*

Session	1	2	3	4	5	Total
Positive Resp						
POS1	11	12	22	25	18	88
POS2	4	9	17	1	7	47
POS3	0	3	0	4	2	9
<i>POS TOTAL</i>	<i>15</i>	<i>24</i>	<i>39</i>	<i>39</i>	<i>27</i>	<i>144</i>
Negative Resp						
NEG1	14	8	3	16	5	46
NEG2	4	2	2	1	5	10
NEG3	6	19	15	3	2	45
<i>NEG TOTAL</i>	<i>24</i>	<i>29</i>	<i>20</i>	<i>20</i>	<i>8</i>	<i>101</i>
Neutral Resp						
NEU1	34	36	109	31	39	249
NEU2	12	7	27	21	12	79
<i>NEU TOTAL</i>	<i>46</i>	<i>43</i>	<i>136</i>	<i>52</i>	<i>51</i>	<i>328</i>
Session	1	2	3	4	5	Total
Missed Opps	12	16	6	14	15	63
Clinical	10	4	2	9	2	27
Total Codes	107	116	203	134	103	663
Total TT	418	189	278	184	301	1,370

Note. TT = Talk Turns

Table 7

*Frequency Data for Therapist-Participant Responses Within and Across Sessions-
TRAUMA DISCUSSION SECTIONS*

Session	1	2	3	4	5	Total
Positive Resp						
POS1	3	12	20	21	12	68
POS2	2	7	14	8	3	34
POS3	0	3	0	3	1	7
<i>POS TOTAL</i>	<i>5</i>	<i>22</i>	<i>34</i>	<i>32</i>	<i>16</i>	<i>109</i>

(continued)

Session	1	2	3	4	5	Total
Negative Resp						
NEG1	4	8	3	15	2	32
NEG2	4	2	2	0	0	8
NEG3	2	19	14	2	2	39
<i>NEG TOTAL</i>	<i>10</i>	<i>29</i>	<i>19</i>	<i>17</i>	<i>4</i>	<i>79</i>
Neutral Resp						
NEU1	11	35	74	14	22	156
NEU2	2	6	20	15	12	55
<i>NEU TOTAL</i>	<i>13</i>	<i>41</i>	<i>94</i>	<i>29</i>	<i>34</i>	<i>211</i>
Missed Opps						
Clinical	3	16	5	14	12	50
	5	4	1	9	1	20
Total Codes	36	112	153	101	67	469
Total TT	109	159	178	113	142	701

Note. TT = Talk Turns

Table 8

Frequency Data for Therapist-Participant Responses Within and Across Sessions-NON TRAUMA DISCUSSION SECTIONS

Session	1	2	3	4	5	Total
Positive Resp						
POS1	8	0	2	4	6	20
POS2	2	2	3	2	4	13
POS3	0	0	0	1	1	2
<i>POS TOTAL</i>	<i>10</i>	<i>2</i>	<i>5</i>	<i>7</i>	<i>11</i>	<i>35</i>
Negative Resp						
NEG1	10	0	0	1	3	14
NEG2	0	0	0	1	1	2
NEG3	4	0	1	1	0	6
<i>NEG TOTAL</i>	<i>14</i>	<i>0</i>	<i>1</i>	<i>3</i>	<i>4</i>	<i>22</i>
Neutral Resp						
NEU1	23	1	35	17	17	93
NEU2	10	1	7	6	0	24
<i>NEU TOTAL</i>	<i>33</i>	<i>2</i>	<i>42</i>	<i>23</i>	<i>17</i>	<i>117</i>
Missed Opps						
Clinical	8	0	1	0	3	12
	5	0	1	0	1	7

(continued)

Session	1	2	3	4	5	Total
Total Codes	71	4	50	33	36	194
Total TT	309	30	100	71	159	669

Note. TT = Talk Turns

Content Analysis Synthesis: Across Sessions/Participants

This section offers frequencies and qualitative examples of all codes across participants (including those within the positive, negative, neutral and adjunctive categories). It focuses on qualitative samples of coded statement quotations to compare results obtained from fully coded sessions (FCS), as well as trauma discussion sections (TDS) versus non trauma discussion sections (NTDS). Given the area of interest for this study is TDS, most of the examples are pulled from TDS responses. The codes are presented from most prevalent within the TDS to least prevalent within the TDS.

Findings are summarized in Table 9.

Table 9

Frequencies Across Sessions in Order of Highest to Lowest Prevalence

	Across TDS*	Across NTDS	Across Full Session
1-Highest Prevalence	NEU1 (<i>n</i> = 156)	NEU1 (<i>n</i> = 93)	NEU1 (<i>n</i> = 249)
2	POS1 (<i>n</i> = 68)	NEU2 (<i>n</i> = 24)	POS1 (<i>n</i> = 88)
3	NEU2 (<i>n</i> = 55)	POS1 (<i>n</i> = 20)	NEU2 (<i>n</i> = 79)
4	MissedOpp (<i>n</i> = 50)	NEG1 (<i>n</i> = 14)	MissedOpp (<i>n</i> = 63)
5	NEG3 (<i>n</i> = 39)	POS2 & MissedOpp (<i>n</i> = 13)	POS2 (<i>n</i> = 47)

(continued)

	Across TDS*	Across NTDS	Across Full Session
6	POS2 (<i>n</i> = 36)	Clinical (<i>n</i> = 7)	NEG1 (<i>n</i> = 46)
7	NEG1 (<i>n</i> = 32)	NEG3 (<i>n</i> = 6)	NEG3 (<i>n</i> = 45)
8	Clinical (<i>n</i> = 20)	POS3 & NEG2 (<i>n</i> = 2)	Clinical (<i>n</i> = 27)
9	NEG2 (<i>n</i> = 8)		NEG2 (<i>n</i> = 10)
10-Lowest Prevalence	POS3 (<i>n</i> = 7)		POS3 (<i>n</i> = 9)

Note. * indicates the order in which the written summary below is presented

Clarifying questions. Across the five psychotherapy sessions among trauma discussion sections in particular, the most commonly found code was from the Neutral Category, specifically that of *Clarifying Questions* (NEU1; FCS: 249 codes; TDS *n* = 156 codes; NTDS *n* = 93 codes). *Clarifying Questions* occurred 18.18% of the time across full sessions, and occurred most frequently across sessions in trauma discussion sections (occurring 22.25% of the discussion), versus non trauma discussion sections (13.9% of NTDS). *Clarifying Questions* included instances of the therapist-participant asking questions to gather information or facts regarding the content of the traumatic event or about the client’s affective experience. To be coded as a clarifying question, the question must have been aimed at checking the listener’s understanding of the essential meaning of the original expression by the client, not simply spontaneous inquiries by the therapist to reach deeper meaning (e.g., “why” questions).

An example of a *Clarifying Question* (NEU1) by therapist-participant 1 (session 1) occurred during the trauma discussion, when the client began to describe the pattern of events by which her uncle used to sexually molest her (C59). The therapist interrupted

the client to utilize the *Clarifying Question*, “What do you mean by first time?” (T60-61) to which the client responded, “the first time he did it” (C61) and continued on to describe her feelings and how she broke the cycle of abuse. Another example within a trauma discussion can be found in the second transcript, in which client-participant 2 began to describe an upcoming medical operation she was going to have on her eye. She said,

And, um, a part of this whole operation is I am not scared of the operation, which is something I probably wouldn't have said a couple years ago. I would have been terrified of having an operation. But I am terrified of the outcome.

The therapist-participant responded to this disclosure with a *Clarifying Question* (NEU1) asking, “It is in two days?” The client-participant responded in C11 stating, “Yeah, it is on Thursday.” In both instances, the client-participant was expressing feelings about the trauma, as well as past or upcoming fears; however in both cases, the trainee therapists chose to respond with a *clarifying question* to gather information regarding a factual detail.

An example of a *Clarifying Question* found outside of the trauma discussion exists in transcript 4 when the client and clinician meet for the first time, and begin the session with small talk about the client's children. The client stated, “and I have a 5 and 18month old that looks just like her. Mini me, and I have two 18 year olds,” to which the therapist-participant asked, “Two 18 year olds, one is your previous husband's 18?”

Validating responses. Occurring second most frequently across all psychotherapy sessions and in the trauma discussion sections, and third most frequently in non trauma discussion, was the positive code of *Validating Responses* (POS1). This

code was used 88 times across the fully coded sessions, 68 of which occurred within the TDS, and 20 in NTDS. *Validating Responses* occurred 6.5% of the time across full sessions, and occurred in 9.7% of the trauma discussion, versus non trauma discussion sections (2.99%). *Validating Responses* (POS1) were coded when the therapist-participant expressed a statement relating understanding and/or acceptance of a client's thoughts, feelings and/or behaviors related to the traumatic event. This code included reflection statements as long as the statement was categorized as a "complex" reflection; which was paraphrasing, reflecting the inferred meaning of a statement, or reflecting feeling, when the clinician used paraphrasing to focus on the emotional aspect of the statement. These types of reflections were included, as each type of reflection added new meaning to the client's statement showing understanding and acceptance of the deeper meaning of what the client had said.

Examples of this type of response within the TDS include the therapist's response to C149 in transcript 3. The client said,

You know I just went to my sister and all her little things right there and her stuff for school, everything's just there and she don't care about, you know. I don't know, I just feel really angry with her,

and the therapist responded with a validating response conveying acceptance and understanding of the client's emotions: "You have a lot to feel angry with her, you have a right to feel angry with her." Also within the trauma discussion sections of transcript 5, the client and therapist talked about how the client's mother treated her as a child and some of the sexual abuse she went through ending with (C271), "That is... yea and that is

the point at which I left and never came back” and the therapist responded with a *Validating Response*, “It is extremely, extremely traumatizing.”

An example of a *Validating Response* that occurred outside of the bounds of the trauma discussion was found in transcript 3, T53. The therapist-participant stated, “So it looks like you’re like, so this is like, this, your symptoms seem to be a lot better than they were a few weeks ago.”

Reflection/summary. The second neutral category, *Reflection/Summary* (NEU2) was used 79 times across fully coded sessions (55 times across trauma discussion sections, 24 times across NTDS). It presented as the third most frequent code within the TDS and FCS, and second most frequent code in NTDS. *Reflection/Summary* responses occurred in 6% of the FCS discussion, 9.2% of TDS discussion and 3.58% of NTDS discussion. This code was used when the therapist-participant utilized a “simple” reflective statement or summary statement that directly and concretely repeated back the content or affective experiences of the events that occurred in the client’s discussion, without inferring, suggesting, or adding meaning to what client originally said.

An example of this type of response found outside of the trauma discussion bounds included a reflection by the therapist-participant in session 1 (T139), “All those things can be sad,” after client-participant described sadness in C138. Examples of *Reflection/Summary* statements within the TDS include, the therapist-participant in session 2 repeating “Thursday” (T11) after the client-participant told the therapist that her surgery was on Thursday (C11), and in session 3 (C228) when the client stated, “She did it before,” and the therapist-participant reflects (T229), “She’s done it before, okay.”

Missed opportunities. Occurring 63 times across sessions was the *Missed Opportunities (+)* code, comprising 4.6% of FCS discussion and classifying as the fourth most frequent code. In the TDS, the code was also fourth most frequent, and occurred 50 times (7.13% of all TDS discussion), versus the NTDS, where the code only occurred 13 times (1.94% of NTDS discussion), and was fifth most frequent. These codes were mostly coded as adjuncts to main codes coming from the three main categories (Positive, Negative, and Neutral), and also were coded on their own when appropriate (e.g., if the response did not fit a main code or could not be coded- though facilitative statements that were left out from main codes, were also not coded in these instances).

These codes were added or coded when there was a clear missed opportunity for a positive response by the therapist-participant. For example, in the *Clarifying Question* section above, the second example utilized from transcript 2 in which the client described her fears about the outcome of an upcoming eye operation (C10) and the therapist responded with the clarifying question (T10), “It is in 2 days?” was coded as NEU1 as it was a clarifying question as described above, and was also coded as a clear missed opportunity (+) to utilize a positive response to speak to or validate client’s affective experience or fear, to support the client, or to empathize with the client. Another example, this time of a stand-alone *Missed Opportunity* code during TD, was found in transcript 5, after the client described how she used to count the days until she turned 18 in order to escape her mother’s abuse in C221, “Wrote it out on a spreadsheet style by hand and that was the day I decided that I wanted to die because I couldn’t live that long.” The therapist here replied, “and you did” which was coded as simply a *missed opportunity* given the opportunities to show understanding/acceptance of client’s

feelings, support the client, and/or empathize with the client after such an affectively intense disclosure.

Outside of the TDS, missed opportunities were also found and coded. For example, in transcript 1 when the therapist missed an opportunity to provide a positive response to the client's discussion of how she related to women (C245-C249), and instead, responded with a clarifying question in T250, "and who is the first person you can think about when you think about that?"

Unempathetic responses. Following missed opportunities, *Unempathetic Responses* (NEG3) occurred as the next frequent coded among trauma discussion sections. *Unempathetic Responses* occurred 45 times total across fully coded sessions (3.2% of all discussion), with a breakdown of 39 times across TDS (5.56% of TDS talk turns), and 6 times across NTDS (0.89% of NTDS talk turns). Responses were coded as unempathetic when the listener was distracted while the client was speaking, demanding of the survivor, or when the listener attempted to push expectations on the survivor.

An example of this code occurred in transcript 4 when the therapist-participant responded to the client-participant's statements in C138-C142. The client-participant was talking about how she feared her daughter would have an "emotional crash," like she had had, and how she wished to heal herself, so that she would be able to be there for her daughter in the future. The therapist-participant responded with "...um, could I ask you a couple of more questions?" in T143, which was coded as unempathetic due to its dismissive nature. Another example occurred in transcript 2, at the end of a verbal exchange beginning with the therapist-participant reflecting the idea of loss to the client. She stated in T126, "So you have had to deal with the possibility of a lot of loss lately"

and the client-participant replied, “Well, yes, but I didn’t know that at the time. It’s only been since I have been healed that my food guy told me that it would have been a foot amputation. It wouldn’t have been...” The *unempathetic code* was identified after the above verbal exchange, when the therapist-participant began to push her expectations on the survivor, by stating, “But even the thought of losing a toe, that’s a loss.” The client continued to clarify her point of view, differing from that of the therapist, afterwards.

An example of a FCS *Unempathetic Response* would be T56 from transcript 3, in which the clinician performed an assessment of the client’s suicidality based on a written assessment the client has previously filled out. She asked her multiple times if she was suicidal, to which the client replied, “No” numerous times. When the clinician continued to ask, the conversation culminated in T56, “Okay, so ‘I have thoughts of killing myself but would not carry them out’, so you don’t have any.”

Supportive responses. Supportive Responses (POS2) were the sixth most frequently coded responses within the TDS (and 5th for NTD and overall). Overall, codes that qualified as supportive responses occurred 47 times across the five transcripts (3% of discussion across sessions). Thirty-four of these codes occurred within the trauma discussion sections (4.85% of TDS talk turns), while 13 codes occurred across NTDS (1.94% of NTDS talk turns). Responses were coded as *Supportive Responses* when the therapist-participant responded in a way that encouraged the client to share further, and/or in a way that advocated for or empowered the client-participant.

One example of this code was in transcript 3, when the client reported that she was feeling down on herself and as if she were “crazy” like her family. The therapist supported and empowered her in T187 by saying:

Okay so then let's look, so in your whole life, you're twenty one, twenty one years and you've gotten, and you've told me, so you, you get angry about things sometimes, you get really angry, but even in your most angry, you've never done anything like your family.

The client agreed in C187. Another example included the therapist-participant in transcript 4 having summarized what the client had identified as her presenting problem (a recent incident with her daughter that was triggering her traumatic response) and encouraged her to talk about it, "You wanna tell me a little bit about that?" An example of a *Supportive Response* outside of the TDS bounds includes the therapist's response to the client sharing about her husband's recent behavior in T32, "I'm hoping that he continues to surprise you."

Invalidating responses. The seventh most frequent code across trauma discussion sections (TDS) was represented by *Invalidating Responses (NEG1)*, which occurred a total of 32 times (4.56% of TDS talk turns). Across all fully coded sessions, this code was the sixth most frequent, and occurred 46 times (3.36% of discussion). Across NTDS, this response occurred 14 times (2.09), and occurred more frequently, as fourth most common code.

Invalidating Responses (NEG1) were coded when the therapist participant met the client's disclosure with an inappropriate, punishing, trivializing, or judgmental response, and/or met the disclosure with a dismissive response. Examples of this code were found in transcript 1, in which the therapist-participant and client-participant were playing a therapy board game. The client rolled the dice and seemed nervous about rolling a three, in which she would have to talk about something she will never forget. The client seemed

to also be aware that she planned to share her traumatic experience with the therapist, and seems to express her anxiety as she stated in C46, “Don’t get three please. Oh gosh (rolls dice- rolls a three)- Oh no, I’m leaving,” to which the therapist responded with “Why are you so upset about this?” The therapist’s response, T47, was categorized as a negative and invalidating response, conveying no understanding or acceptance as to why the client might be upset, and trivializing the situation.

Another TD example was found in transcript 3, after the client shared the following memory in C166:

So one time I get so angry I saw [sic] I’m going to call the police and this and that and my grandma and my aunt go, ‘If you do that, you’re gonna go live with the streets,’ cause this and that, ‘cause she’s family, you can’t do that’ this and that. She got so pissed with all of them. Cause they see how much she suffering and they think its okay. They think she can do that cause she’s mom she can do that, you know?

The therapist then replied, “It sounds like, you know, you don’t.. I mean I noticed you said the whole family is crazy” (T167), which was coded as invalidating (NEG1) as well as a missed opportunity (+; description above).

An example of a NEG1 response from a non-trauma discussion section began with the client describing how she would like to be, in response to a certain situation regarding children, (C277-278) which she ended by saying, “I’m not there” (C129). The therapist-participant then replied, “That’s abusive to yourself, to be, to have to become that way. Because then you’re, cause what you’re doing to yourself is, there’s something that’s bothering you, You’re hated.”

Clinical codes. While they occurred less frequently than the previously mentioned codes (eighth most frequent across TDS and FCS, sixth most frequent across NTDS), *Clinical* (*) codes were also found among the coded responses. *Clinical* codes were coded a total of 27 times (1.97% of discussion) across FCS transcripts. Clinical language was found 20 times (2.85% of discussion) across TDS, and 7 times (1.05% of discussion) across NTDS. These codes were assigned to any responses, (either as part of a main code, or standing alone), in which the therapist-participant performed any type of clinical assessment, such as: asking questions about the client’s symptoms, how they are coping, what their strengths or support systems are; or when a therapist-participant utilizes clinical terminology when speaking to client about traumatic event or presentation. Diagnostic assessments or discussions as well as psychoeducational discussions were also included in this category, and were coded when in relation to traumatic events, recovery, symptom presentation, or treatment.

One example was found in a discussion occurring in transcript 1, during which the clinician provided psychoeducation about trauma/CBT to summarize content to the client-participant. In T98, the therapist-participant stated, “You know? When you’re a child, you experience certain things, and that becomes your core belief.” Another instance was in transcript 5, when the therapist-participant was discussing the client’s PTSD symptoms in T278, “It seems like you only really physically experience the trauma, but when you’re having your nightmare you said you were shaking and...” An example of a non trauma discussion code including clinical data occurred in transcript 3, T53, when the therapist stated, “So it looks like you’re like, so this is like, this, your symptoms seem to be a lot better than they were a few weeks ago.” This response was

used as an example earlier to denote a *Validating Response*; however it was adjunctively coded as *Clinical* given the content of symptoms.

Unsupportive responses. *Unsupportive Responses* (NEG2) which occurred only 10 times across all five transcripts (0.7% of FCS discussion), were the second-to-least found code across sessions. Across trauma discussion sections, unsupportive responses were found 8 times (1.14% of TDS talk turns) and were also the second to least frequent code, and only 2 times (0.3% of NTDS talk turns) across NTDS, making this code tied for least frequent response among the NTDS. A response was coded as an *unsupportive response* if the therapist-participant exhibited disbelief about the traumatic event, if he/she belittled the client, reacted with outrage or horror at the survivor, offender, or non-protective social supports of the survivor. The codes occurred with a mean of only 2 times per session ($SD = 1.22$).

An example of the therapist-participant belittling the client-participant occurred in transcript 1. The therapist-participant had asked in T92 if the client-participant having been molested impacted her sexually and offered an interpretation in T93 about whether the client might feel the need to be more in control while having sex. The client-participant quickly answered in C93, “No, I don’t.” The therapist-participant then tried to explain in T95, perhaps in a general way, about how individuals might feel after having been molested. When the client responded with, “Oh really?,” the therapist’s response was coded as unsupportive in T96,

Yea, because you know they want, it’s obvious that the uncle said, ‘I’ve done these things for you’ And therefore you have to pay up. And what you’re saying is well then nobody is allowed to do anything for me because then.

This response was deemed as having been belittling to the client given the phrase, “its obvious that,” and that the therapist-participant was not fully listening to the client.

Outside of trauma discussion bounds, an example occurred in transcript 4 in T147, when the clinician asked the client “um, history of substance use?” Although the client replied, “no,” the therapist said, “none, never, or just some..” inferring that she was not fully listening to the client or did not believe her.

Empathic responses. The least frequently occurring code across all discussion types was found among the positive category of codes, that of *Empathic Responses* (POS3). These codes only occurred 9 times across all FCS discussion (0.65% of talk turns); 7 of which occurred within the TDS (1.0% of discussion), and 2 of which in the NTDS (0.3% of discussion). *Empathic Responses* were coded when the therapist-participant verbalized how she/he was able to imagine that she/he was the other person who experienced the situation. These examples were only coded if the therapist-participant utilized a direct “I statement” to show a clear depiction of empathy to the listener. Furthermore, these responses included expressions or responses related to the therapist-participant’s personal disclosures regarding his/her ability to engage in the experience as if he/she actually had the feelings, thoughts, and behaviors of the survivor; and expressions related to the therapist-participant inferring or imagining what it would be like to have had those thoughts, feelings, and behaviors of the survivor.

For example in session 2, the therapist responded to the client’s description of her upcoming surgery (C81) with an empathic response in which she shared her own feelings about the situation, “It sounds very scary to me.” Also, in transcript 4, after the client described the molestation and how she dealt with the feelings (C52, C53), the therapist

empathically replied, “I can never begin...” An example of an *Empathic Response* outside of the trauma discussion bounds was found in transcript 5 when the client discussed how she was having difficulty trusting her husband (C113-114), to which the client replied, “I’m sure it’s hard to, to allow you to fully trust him.”

Frequencies of non-coded expressions. Across the five sessions, a number of non-coded expressions occurred, including facilitative statements, compliments, and advice giving/therapist opinion. These responses were unable to be coded due to the lack of knowledge regarding the therapist vocal tone, facial expression, body language, and overall flow of session. Additional problems with interpreting these codes as positive, negative, or neutral included a lack of knowledge regarding therapist intent, and most importantly, how the client-participant received the response. While these responses were not coded for this study, they still contain vital data to understanding the across session summary, and were thus kept track of generally throughout the coding process and are next discussed.

A total of 679 facilitative statements (e.g., mm-hmm, uh-huh, yes, okay, right, etc.) were made across all five sessions, ranging from 52 to 212 depending on the session ($m = 135.8$, $SD = 74.11$), occurring much more frequently than any code. Additionally, 49 compliments were given by therapist-participants to client-participants, across the five sessions, ranging anywhere from 5 per session to 18 per session ($m = 9.8$, $SD = 5.89$), which was comparable to mid frequency rating of other codes. Advice giving behavior, or therapist opinions were shared relatively infrequently, on 17 occasions across sessions, range of 0 to 11 ($m = 3.4$, $SD = 4.39$).

Across the five sessions there were also variations in types of trauma experienced and/or discussed. Client-participants 1, 3, 4 and 5 had experienced childhood sexual abuse and either discussed or disclosed some or all of the events within each of the sessions. One client, client-participant 2 experienced and discussed medical trauma. Client-participants 3 and 5 also discussed histories of childhood physical abuse, and client-participant 5 discussed her experience of domestic violence. Although a few patterns were found when codes were viewed in relation to the types of trauma across sessions (e.g., CP2's session contained the most NEG3 and Missed opportunities during trauma discussions when compared to other sessions with client participants who experienced non-medical traumas), it is difficult to conclude that such differences are related to the type of trauma experienced given the variety of other factors, including CP2's session having the least number of nonTD codes as well as therapist characteristics, therapist mood, countertransference, etc..

Differences in trainee-therapist responses across types of discussion were found, and occurred across FCS, TDS, and NTDS sections. While neutral responses were the most popular across all full sessions, when looking at trauma discussion specifically, all trainee-therapists, with the exception of trainee therapist-participant 4, utilized neutral responses the most frequently. During the trauma discussion, therapist-participant 4 had 3.1% more positive codes than neutral codes (POS $n = 34$, NEU $n = 29$, NEG $n = 17$). In addition, trainee therapist-participants 3, 4, and 5 tended to utilize more positive responses than negative responses when looking at both fully coded sessions and TDS.

Content Analysis Synthesis: Within Sessions/Participants

The following section presents data for individual transcribed sessions. A presentation of code frequencies and qualitative descriptions of codes within the context of the session, and specific statements that characterize responses by therapist-participants during discussions of trauma are reported for each transcribed session. Both the entire transcribed session as well as the specific trauma discussion sections for each transcript will be discussed, and results are presented in the order of most frequently occurring. Non-verbal behaviors were not explored in this study, and therefore will not be included in the session-by-session results.

Session 1. As previously discussed in the methods section, Transcript 1 involved a female Therapist-Participant and a 28-year-old, African-American, heterosexual, female Client-Participant who identified as Christian. The coders and previous dissertation lab teams experienced her presentation as that of an expressive, playful, and resilient woman. Client-Participant 1's identified trauma was having been raped by her uncle when she was in third grade.

In the coded session, a psychotherapy board game was played by the therapist-participant and client-participant. With a roll of the dice, the client-participant, and therapist-participant were asked to answer questions that ranged from light to serious, and throughout the session, Client-Participant 1 discussed a range of topics including romantic relationships, current difficulties with her boyfriend, her sexual abuse history and trauma, and interpersonal concerns.

For the purpose of this study, all talk turns were reviewed; however, only the therapist talk-turns were coded, as the study aimed to explore trainee therapist

responses/reactions to trauma disclosure/discussion with trauma survivors. Session 1 consisted of 418 therapist talk turns. All together, 107 responses (or 25.6% of talk turns) were coded in session 1. After reviewing and coding the entire session, the sections of the transcript that included trauma discussion/disclosure were determined, reviewed, and analyzed separately. Trauma discussion for session 1 was deemed to include three separate sections: (a) C46-T120, (b) T155-T157, and (c) T210-C244. These sections totaled 109 therapist-participant talk-turns within session 1's trauma discussion section. This means that 26.07% of session 1 was considered to be trauma discussion (TDS), whereas the remaining 309 talk turns were considered to be outside of the trauma discussion section (NTDS, 73.93% of session 1). Thirty-six responses of the 109 TDS talk turns were coded (33.64% of the trauma discussion). However, this data should be interpreted in light of the fact that on occasion, responses met criteria for more than one code within the same talk turn. Within session 1's 309 remaining NTDS talk turns, 71 responses were coded (22.97% of the NTDS section).

A further breakdown of this information includes the types of responses found in session 1, separated out by types of discussion. Of the full coded session (FCS) coded responses, 43% were coded as neutral, 22.43% were coded in a negative direction, 14% were coded in the positive direction, 11.21% were considered missed opportunities, and 9.35% contained clinical language. In regards to the trauma discussion sections (TDS) in particular, 36.11% of the codes were considered neutral, 27.78% of the codes were coded in the negative direction, 13.89% were coded as positive, 13.89% contained clinical language, and 8.33% were considered to be missed opportunities. There were 71 codes that fell outside of the trauma discussion in session 1 (NTDS), 46.48% of which were

neutral, 19.71% negative, 14.08% positive, 12.68% missed opportunities, and 7.04% clinical. The results of session 1 are presented in the order of highest frequency category to lowest frequency category within the TDS, as that is the area of interest for the study.

Neutral responses. As stated above, *Neutral Responses* were coded most frequently, independent of type of discussion. Thirteen out of 36 codes (36.11%) within the trauma discussion section and 33 out of 71 codes (46.48%) in the NTDS were classified as *Neutral Responses*; and 46 of the 107 codes (43%) in the FCS were considered neutral. Examples of the types of neutral responses that the session 1 therapist-participant utilized included the overall most frequently coded response, *Clarifying Questions* (NEU1; TDS: 11 codes, 30.55% of codes), and less commonly, *Reflections/Summary* statements, (NEU2; TDS: 2 codes, 5.55% of codes).

Clarifying questions. The code NEU1 occurred regularly, 11 times, within trauma discussion sections, and 23 additional times outside of trauma discussion. These responses tended to occur when the clinician was attempting to gather more information from the client, about her life, or the game, and/or after the client was finished sharing about her traumatic experiences. Examples within TDS included the therapist-participant asking the client, “Did it change anything in you after that? After it happened?” (T75) after the client-participant shared her experience of the sexual abuse she suffered as a child. Later in the session, another example emerged when the therapist-participant asked the client, via the board game, to share something that came to mind when she thought about her childhood. The client-participant began to again speak about the abuse, and her views on it as she looked back. She stated,

Now yes, he should ask for ID, but the chick's got a body that looks older than I, with a baby face. You know what I'm saying?..(C217)

So to me, that would, that would be like, okay yes you got abused, but you asked for it. You know what I'm saying? (C218)

To which the therapist-participant responded with a *Clarifying Question* "You're talking about 15, 16 year olds now right?" (T219).

This type of response also occurred frequently outside of the trauma discussion. For example, in C141, the client-participant explained a scenario in which she had been looking for a job and was offered something with which she did not feel legally comfortable. She ended the disclosure with C142, by saying, "So that sucked because I was one step away from getting passed a job." The therapist-participant replied with a clarifying question in T143, "and that was Monday?"

Reflections/summaries. The code NEU2 occurred only twice within trauma discussion, but occurred 10 other times outside of the trauma discussion sections. Examples within TDS included the therapist-participant summarizing, "you told me about your uncle, yea" (T57), as well as, trying to summarize/reflect and connect past information the client had shared, after her disclosure of the sexual abuse in C58-C72, "You said you learned to disrespect... or like not give um respect to all adults... because they're not, they don't deserve it (T76-78). An example outside of the trauma discussion occurred after the therapist-participant asked how many years older the client's brother was than her (T204). The client-participant responded "two" (C204), and the therapist-participant responded with a direct reflection, "two years older" (T205).

Negative responses. As stated above, *Negative Responses* were the second most coded category in session 1 within the trauma discussion section. Ten out of 36 codes (27.78%) within the trauma discussion section, 14 of 71 codes (19.72%) in the NTDS, and 24 of the 107 (22.43%) full session codes were classified as *Negative Responses*. Examples of the types of negative responses that the session 1 therapist-participant utilized included *Invalidating Responses* (NEG1) and *Unsupportive Responses* (NEG2); both of which occurred only 4 times each in the TDS (NEG1: 11.11% of codes in TDS; NEG2: 11.11% of codes in TDS). The least frequently used negative response within the trauma discussion section of session 1 was *Unempathetic Responses* (NEG3; TDS: 2 codes, 5.56% of codes).

Invalidating and unsupportive responses. *Invalidating responses* (NEG1) occurred 10 additional times outside of trauma discussion, while *Unsupportive Responses* did not occur outside of the trauma discussion.

Invalidating responses tended to occur when the therapist-participant in session 1 was giving her opinion, and/or trying to comfort the client. An example within the trauma discussion of an invalidating response included when the therapist-participant attempted to utilize an example of another client she had seen who had experienced child sexual abuse. She stated,

...and it's too confusing so she doesn't remember, but so she came to a psychologist, asking did, why, did this happen to me or not?... And obviously, I don't know if it happened, you know? The therapist doesn't know if it happened to her

Examples from outside the trauma discussion section included the therapist-participant's response to the client-participant's discussion about having high standards for herself and for repairing relationships in the future. Though it seems as if the therapist was trying to have the client work towards more self-compassion, she stated in T280, "That's abusive to yourself, to be, to have to become that way" which was coded as invalidating. An example of an *Unsupportive Response* in the TDS occurred at T96-97 when the therapist-participant was attempting to explain how, generally speaking, a "client who was molested" might experience things. She stated, "Yea, because you know they want, it's obvious that the uncle said I've done these things for you..." "And therefore you have to pay up. And what you're saying is well then nobody is allowed to do anything for me because then..." which was considered unsupportive.

Unempathetic responses. The code NEG3 occurred only twice within trauma discussion, but occurred 4 other times, outside of the trauma discussion sections. These responses tended to occur in the context of the therapist-participant pushing expectations on the client or being demanding of the client-participant. An example of this within the TDS included the therapist's response in T95. The scenario began in T91-T92 with the therapist inquiring about whether the sexual abuse the client suffered as a child, and just had disclosed, had impacted her sexually. The client stated in C92, "Not that I know of," and the therapist-participant continued to ask in T93, "like do you feel like you need to be more in control, when you're having..." to which the client-participant again replied, "No, I don't" and "Yea, no I don't" consecutively. As the therapist-participant went on further, stating, "I mean, like you know, clients who have been molested when they were a child, um what you're saying is, is something that a lot of them have..." this was

considered to be an unempathetic response as the clinician was continuously pushing her own expectations on the client-participant, despite the client-participant's clear response. An example of this outside of the TDS included a scenario at the beginning of the session, when the client-participant seemed a little wary of playing this game and discussing her feelings, to which the therapist-participant responded, "Umm, ya, it's a psychology game, you gotta get..." "those emotions out" (T26-27).

Positive responses. As stated above, the least common category found in session 1's trauma discussion section was that of *Positive Responses*. Of the total 36 codes within the TDS, *Positive Responses* accounted for only 5 codes (13.89%); within the NTDS's 71 codes, only 10 were considered positive (14.08%); and in the full session, 15 of the 107 total codes classified as a positive response (14.02%). Examples of the types of positive responses that the session 1 therapist-participant utilized included *Validating Responses* (POS1) and *Supportive Responses* (POS2); occurring 3 and 2 times respectively within the TDS (POS1: 8.33% of codes in TDS; POS2: 5.56% of codes in TDS). *Empathic Responses* (POS3) were not utilized at all by the therapist-participant in session 1.

Validating responses. In addition/contrast to providing validating responses 3 times within the trauma discussion section (109 total talk turns), *Validating Responses* (POS1) occurred 8 additional times outside of trauma discussion. An example of the therapist-participant conveying a validating response to the client's discussion of trauma occurred in T72, the therapist-participant utilized a complex reflection to show understanding, "So like, you had to kind of, kept being babysat by him while you had this like, disgust." Another example occurred in T79 when the therapist-participant attempted to convey validation by saying, "obviously he doesn't," when referring to the client-

participant's perpetrator, and whether or not he deserved respect. An example of a validating response that occurred outside of the trauma discussion section included the client-participant describing a difficult relationship, and her frustrations with events that had happened, "wishing that [she] could just forget about it period" (C265), and the therapist-participant validates her by saying, "you can't, that's tough" (T267).

Supportive responses. The POS2 code occurred only twice within trauma discussion, and occurred 2 additional times outside of the trauma discussion sections. Within the trauma discussion section, the therapist-participant stated, "But do you want to talk about it? What happened?" (T54) which was encouraging the client to discuss the trauma if she felt comfortable. An example outside of the TDS occurred at the beginning of the session when the therapist-participant encouraged the client-participant to discuss/disclose openly by saying, "Anything you want to tell me about" (T39).

Empathic responses. The therapist-participant in session 1 did not utilize *Empathic Responses* (POS3) at all during the session, either in trauma discussion sections, or in non trauma discussion sections.

Adjunctive responses. In session 1, specifically within trauma discussion sections, *Clinical responses* (*) were found to be the second most frequent individual code (first most frequent individual code being *Clarifying Questions* (NEU1)), and were used mostly as an adjunctive code to an existing coded response. The therapist-participant in session 1 utilized 5 *Clinical responses* (13.89% of TDS codes). Five additional instances of clinically coded responses existed outside of trauma discussion sections. These responses tended to be utilized by the therapist-participant while trying to explain a clinical concept or normalize the client's experience. An example within the TDS

included T98, when the therapist-participant stated, “When you’re a child, you experience certain things, and that becomes your core belief.”

The second adjunctive code, *Missed Opportunity* (+), was coded 3 times during the trauma discussion section for session 1 (8.3% of TDS codes). Nine additional instances of missed opportunity codes existed outside of trauma discussion sections. These responses tended to be utilized by the therapist-participant when the therapist responded with either a neutral or negative response, and there was a clear missed opportunity to validate, support, or empathize with the client. For example, after the client discloses her trauma narrative, the therapist stated, “Did it change anything in you after that? After it happened?” (T75). This was coded as a missed opportunity given the fact that the therapist-participant could have given a positive response instead of the question, or prior to the question.

While the following categories were not included in coding due to the coders’ inability to classify them as positive, negative, or neutral in nature, facilitative statements, compliments by the therapist-participant, and therapist advice/opinions were kept track of throughout the coding process and counted. In session 1, the therapist-participant utilized 207 total facilitative statements including the following; Mm-hmm (174), Uh-huh (9), Okay (8), Yes/Yea (7), Mm okay alright (2), oh (1), Oh my (1), right (1), yea yea ok (1), Um okay yea (1), Huh (1), and Hmm (1). In addition to facilitative statements, the therapist-participant complimented the client a total of 18 times, including; that’s good/good (5), Wow that’s really cool (1), That’s kind of beautiful too (1), I wish I had that answer (1), and Oh okay good, good (1). There were no instances of therapist giving advice or opinions in transcript 1, however the therapist did utilize an example within the

session that included another client she had worked with who had been sexually molested by her father. The therapist spoke about that client's feelings, as an example of how a person who was molested might feel. Additionally she used an example of R. Kelly, a famous singer accused of sleeping with young adolescent girls, to inadvertently blame the perpetrator and relinquish guilt or blame from the survivor. As the coders' were unable to tell how these examples were received by the client-participant, they were unable to be coded, but should be noted as they occurred uniquely in transcript 1, during the trauma discussion sections.

Session 2. As previously discussed in the methods section, Session 2 involved a female therapist and a 47-year old, European-American, single, heterosexual client-participant. The previous team's lab observed the client's presence in the transcript to be that of someone soft-spoken and mild-mannered, and her therapist described her as "pleasant and friendly" and "positive" in the intake evaluation form. Client-participant 2 reported suffering a stroke about one year prior to seeking therapy, after which point she began losing her eyesight. 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.

In the coded session, the coders found the client-participant 2 to be agreeable, frequently acquiescing to the therapist's suggestions/interpretations. The session used for this research study included a discussion of a range of topics by Client-Participant 2, including the client's upcoming medical surgery, scratching behavior, her medical problems/physical limitations, and her social support system.

Session 2 consisted of 189 therapist talk turns. All together, 116 responses (or 61.38% of talk turns) were coded in session 2. After reviewing and coding the entire session, the sections of the transcript that included trauma discussion/disclosure were determined, reviewed, and analyzed separately. Trauma discussion for session 2 was deemed to include one trauma section beginning at C7, ending at C166. There were 159 total therapist-participant talk-turns within session 2's trauma discussion section, and 30 total therapist-participant talk-turns outside of the trauma discussion in session 2. This means that 84.13% of the session was considered to be TDS, whereas only 15.87% of the session was considered NTDS. Of the 159 TDS talk turns, 112 responses were coded (70.44%), and of the 30 NTDS talk turns, only 4 were coded (13.33%). This data should be interpreted in light of the fact that on occasion, responses met criteria for more than one code within the same talk turn.

A further breakdown of this information includes the types of responses found in session 2 (e.g., Positive, Negative, Neutral) separated out by type of discussion (i.e., FCS, TDS, NTDS). Of the full coded session (FCS) coded responses, 37.07% were coded as neutral, 25% were coded in a negative direction, 2.69% were coded in the positive direction, 13.79% were considered missed opportunities, and 3.45% contained clinical language. In regards to the trauma discussion sections (TDS) in particular, 36.61% of the codes were considered neutral, 25.89% of the codes were coded in the negative direction, 19.64% were coded as positive, 14.28% were considered to be missed opportunities, and 3.57% contained clinical language. Among the NTDS's 4 codes, 50% of codes were considered neutral, and 50% of codes were considered positive. As with session 1, and for each of the sessions that follow, results of session 2 are presented in the order of

highest frequency of code category, to lowest frequency of code category as dictated by the results in the TDS (given the TDS is the area of interest for the study).

Neutral responses. Out of the total of 112 codes within the trauma discussion section in session 2, *Neutral Responses* were coded most often (TDS: 41 codes; 36.61% of coded responses, NTDS: 2 of 4 total codes, 50% of coded responses). In the full session, 43 of the 116 total codes classified as a neutral response (37.07% of codes). Examples of the types of neutral responses that the session 2 therapist-participant utilized included the overall most frequently coded response, *Clarifying Questions* (NEU1; TDS: 35 codes, 31.25% of codes), and less commonly, *Reflections/Summary* statements (NEU2; TDS: 6 codes, 5.36% of codes).

Clarifying questions. The code NEU1 occurred regularly, 35 times, within trauma discussion sections, and occurred one additional time outside of trauma discussion. These responses tended to occur when the client-participant shared her feelings and thoughts about upcoming medical procedures. Therapist-Participant 2 tended to ask multiple clarifying questions, one after the other, during these circumstances (e.g., clinician asking questions about when, and what specifically will happen). Examples within TDS included an example from the across sessions section above, which involved C9-C10 (the client described her upcoming surgery and how terrified she was about it), and T10, “it is in 2 days?” as a clarifying question. Other examples from the TDS included the therapist-participant’s response after the client downplaying the “majorness” of the medical procedure in C12 and C13, “It is not a major dramatic operation. It’s something that is very run at the mill for them. But.... It’s my eye”.... “It’s my life.” The therapist-participant responded with two consecutive clarifying questions in T13 and T14, when

she asked, “Now it’s inpatient or outpatient?”... “And then they are going to work on which eye?.” Another example from the TDS occurred in the context of the therapist directing the session by discussing different techniques the client should try to stop the scratching, and then prompting more discussion about the surgery in T74, “So the surgery is on Thursday?”; T75, “And then when will you know if it was successful or not?”; and T78, “So you will have clearer vision?” The one example of this type of response in a non trauma discussion occurred in T162 when the therapist-participant stated, “and did you get somebody on the phone?” to the client-participant disclosing she had called the therapist to leave a message, and then had called again before the session.

Reflections/summaries. The code NEU2 occurred 6 times within trauma discussion, and again, only occurred one additional time outside of the trauma discussion section. Examples within TDS included Therapist-Participant 2’s response to the client’s disclosure about “attacking” herself (via problematic scratching behaviors), following the therapist’s prompting clarifying question of, “You did? When was this?” in T36. Client-Participant 2 stated, “Uh, what night was that? Do-do-do-to-do, that was Saturday night,” to which Therapist-Participant 2 responded, “Saturday night.”

The single reflection/summary of session 2 that occurred outside of the trauma discussion occurred in T188 and was in response to the client-therapist’s statement C188:

And I had a big white bandage there and I was giggling because I said, ‘Okay I just filled out that form.’ I said and I talked to [female friend], ‘Probably in an hour, in four different ways was asking if I had any suicidal thoughts or anything’ and here, it looks like I’ve slashed my wrist and was gonna go in with my white bandage on.

Therapist-participant reflected, “With your white bandage on your wrists.”

Negative responses. Out of the total 112 codes within the trauma discussion section in session 2, *Negative Responses* were coded second most often as described above (29 codes of 112 TDS codes; 25.89%). All negative codes occurred within the trauma discussion sections (none occurred outside of these parameters). In the full session of 116 codes, these 29 negative codes accounted for 25% of codes. Examples of the types of negative responses that the session 2 therapist-participant used, included *Unempathetic Responses* (NEG3), classified as the second most frequently coded response in session 2, despite whether trauma was being discussed or not (TDS: 19 codes, 16.96% of TDS codes), *Invalidating Responses* (NEG1) occurred only 8 times, (TDS: 7.14% of codes), and the least frequently used negative response, *Unsupportive Responses* (NEG2; TDS: 2 codes, 1.79% of codes).

Unempathetic responses. The code NEG3 occurred regularly, 19 times, within trauma discussion sections and none occurred outside of the trauma discussion. These responses tended to occur in the context of the therapist-participant pushing her own expectations on the client-participant, many times in a demanding way despite the client’s current disabilities. Examples within TDS included, T53-T63 which occurred after the therapist participant had suggested the client journal/write her feelings to avoid the scratching behavior in T50-T51. The client-participant responded to this suggestion in C53 by stating,

Mm-hmm. Okay. Well right now it would be interesting for me to write because you wouldn’t be able to read what I was writing but that may not be what you want. Do you want me to be able to read what I am writing?

The therapist-participant responded with the following unempathetic responses T53-T63 (which were considered one talk turn) in session 2:

T53-63: No... I think just getting out... and to keep your hands busy and to let go of some of those upsetting feelings 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. You knew you were feeling upset... And so there is a connection between feeling upset and scratching... So maybe we can put a step in the middle and have you write when you are feeling upset. Not for a long time, but maybe just write down some of the things that are bothering you, or maybe what's on your mind or just free flowing thoughts...

While the majority of the client's interim responses had been facilitative statements, in C58-59 she attempted to clarify her process with the therapist-participant as it seemed she disagreed with the purpose of the proposed assignment. Eventually the client acquiesced to the therapist's request:

Yea, and now I am thinking about this though, when I sat down to have a cup of tea, I don't think I was feeling upset... At the time, it was, I had come downstairs and then I checked on [friend] and made a cup of tea and sat down. And I think, well, I'll try it. I'll definitely try it. It's a great idea.

The therapist continued the NEG3 unempathetic response talk-turn (T59-T63) by pushing the client further:

Cause you said you had several frustrating experiences during the day?... And maybe you disconnected with them, felt okay, and had the tea?... And then the

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

Client responded in C63 "Mhmm. No, I, I think..."; and therapist replied, "We can see how it works."

Invalidating responses. The code NEG1 occurred 8 times within trauma discussion, and again, did not occur outside of the trauma discussion section. These responses tended to occur when Therapist-Participant 2 would interrupt Client-Participant 2 in a dismissive way. An example within the TDS included the therapist-participant's response to C38, as the client intended to continue to describe when she "attacked" with her scratching, by saying, "And I..." Therapist-Participant 2 was dismissive of the client who had been attempting to go on, and stated, "Was this in your sleep or while you were awake?" A similar process occurred in C45-T45 as the client continued to describe the scenario/moment before she began "attacking" with her scratching, and stated, "And so I had a cup of tea and I was just sitting there, and let's just say I-" which the therapist-participant again dismissed to presume, "So you were sitting and thinking about the things that were upsetting you, while you were having your tea?"

Unsupportive responses. The code NEG2 occurred only 2 times within trauma discussion, and again, did not occur outside of the trauma discussion section. The two examples of unsupportive responses occurred in T129 and T130, after the therapist-

participant in T128 had spoken to a theme she had observed within the client's discussion, that of feeling like a burden to client's family and friends. The therapist-participant reacted with a low level of outrage about how CP2 was handling the situation, and stated, "Where is that coming from? Because clearly you need to be in the hospital, you needed that bed... Maybe even more than other people but you felt like you didn't deserve that bed."

Positive responses. As stated above, the least common category found in session 2 was that of *Positive Responses*. Of the total of 112 codes within the trauma discussion section in session 2, *Positive Responses* accounted for 22 codes; (19.64% of TDS coded responses), within the NTDS section, 2 of 4 NTDS codes were positive (50%), and of the 116 total codes, 24 were classified as a positive response (20.69% of FCS codes). Examples of the types of positive responses that the session 2 therapist-participant utilized, included *Validating Responses* (POS1), *Supportive Responses* (NEG2), and *Empathic Responses* (POS3), which occurred 12, 7, and 3 times respectively within the TDS (POS1: 10.71% of TDS codes; POS2: 6.25% of TDS codes; and 2.68% of TDS codes).

Validating responses. The therapist-participant in session 2 responded in a validating way, 7 times within the trauma discussion section (112 total talk turns). *Validating Responses* (POS1) did not occur outside of trauma discussion. These responses tended to occur in response to the client-participant discussing the upcoming outcomes for her surgery. An example of a validating response occurred in response to the client-participant sharing the doctor's beliefs about the prognosis of her upcoming surgery in C22. The therapist responded positively, "So, um, I understand that you said

you feel worried about the outcome?” (T22), which was classified as a complex reflection. Another example in the TDs occurred in T31 when the therapist responded, “Understandably,” to the client not being able to remain 100% positive about the outcome of the surgery. A third example occurred in T104-105 when the therapist reflected, “that must be a very painful feeling to know... that you are somewhat helpless.”

Supportive responses. The code POS2 occurred 7 times within trauma discussion, and occurred 2 additional times outside of the trauma discussion sections. These responses tended to occur in the context of the therapist-participant encouraging the client (rather than empowering the client). Examples within TDS included the therapist encouraging the client’s actions and the response that followed in T44, “So having the tea, that was a great idea to sort of calm you down,” encouraging the client to try the writing exercise the therapist had suggested, T73, “That would be good, that would be good,” and encouraging the client bringing two friends to the hospital with her, T88, “That’s good. That’s very good.” The examples of supportive responses that occurred outside the TDS included both T178, when the therapist stated, “if at some point that becomes an issue, please let me know” regarding being able to pay for the therapy fee, and T181 when the therapist encourages the client to talk about her brother coming to visit, in an upcoming session “Okay, we’ll have to talk about that.”

Empathic responses. The code POS3 occurred 3 times within trauma discussion, and no additional times outside of trauma discussion sections. An example of POS3 occurred in T32 when the therapist-participant stated, “I can understand your fears and concerns.” A second example occurred in T81, when the therapist stated, “it sounds very

scary to me,” conveying empathy. The last example of empathic responding occurred in T90, when the therapist responded to the client’s feelings about having been told to expect the worst with her eyesight, “I can imagine.. It’s something that is unknown.”

Adjunctive codes. In session 2, *Missed Opportunities* (+) were found to be the third most frequent individual code across full sessions and trauma discussion sections, and were utilized mostly as an adjunctive code to existing coded responses. In session 2, 16 *Missed Opportunities* were coded (14.28% of TDS codes; 13.79% of all codes). *Missed Opportunities* were not found outside of the trauma discussion section in session 2. These responses tended to be used by the therapist-participant in conjunction with clarifying questions, for example in T82 when the therapist-participant asked, “What about pain? Do they expect that you will have any pain?” Therapist-Participant 2 tended to utilize clarifying questions without positive responses attached, thereby creating a missed opportunity situation. Another example included T102 when the client talked about how she handled things after she had a stroke, and the therapist-participant finished her sentence by saying, “very determined?” rather than encouraging or empowering the client, empathizing, or validating.

The second adjunctive code, *Clinical* responses (*) was coded 4 times during session 2 (3.57% of TDS codes; 3.45% of all codes). Again, this code was utilized mostly as an adjunctive code to an existing coded response. No additional instances of clinical language existed outside of the trauma discussion section. These responses tended to be utilized by the therapist-participant in XYZ context. Examples within TDS included T51 and T52 when therapist discussed the connection between the client’s symptoms and problematic behavior (e.g., feeling upset and scratching); T55, where the therapist related

the connection between thoughts, feelings and behaviors; and T59 where she clarifies the client's symptoms.

While the following categories were not included in coding due to the coders' inability to classify them as positive, negative, or neutral in nature, facilitative statements, compliments by the therapist-participant, and therapist advice/opinions were kept track of throughout the coding process, and were counted. In session 2, the therapist-participant utilized 136 total facilitative statements including the following; Mm-hmm (27), Uh-huh (10), Okay (7), Right (6), Yes/Yea (4), Oh okay (3), wow/oh wow (3), Oh my/oh my goodness (2), Oh (1), I see (1). In addition to facilitative statements, the therapist-participant complimented the client a total of 5 times, including; good/okay good (2), okay excellent/that's excellent (2), that's a good technique (1). There was one instance of therapist giving her opinion in transcript 2 regarding the weather, "Yes it's wonderful."

As compared to session 1, interruptions tended to occur quite frequently in session 2. Interruptions were categorized as two different kinds: one type occurred when the therapist-participant finished the client-participant's sentence for her as she was still speaking (5x); and the other occurred when the therapist-participant seemingly tried to correct the client-participant's thoughts about a certain topic. An example of the second type of interrupting was discussed earlier when reviewing the across sessions results, and included an example of when the clinician reflected that the client had experienced a lot of loss lately, but did not allow client to finish her thought, and instead interrupted to say "but even the thought of losing a toe, that's a loss," to which the client ends up eventually acquiescing.

Session 3. Transcript 3 involved a female therapist and a 21-year old married, heterosexual, Christian, Latina woman as the client-participant. The previous team's lab observed the client-participant's presence in the transcript to typically be serious and tearful, and it was noted client spoke with an accent as Spanish was her first language. Client-participant 3 immigrated to the United States from El Salvador at the age of 19. She reported having experienced extensive physical and emotional abuse from her biological mother and grandmother, in addition to two instances of sexual assault. .

In the coded session, Therapist-Participant 3 would sometimes translate words or phrases into Spanish. The session used for this research study included discussions of a range of topics by Client-Participant 3, including revisiting a previously filled out assessment of the client's current symptoms, the client's family concerns, and physical abuse history.

Session 3 consisted of 278 therapist talk turns, with 203 responses (or 73.02% of talk turns) coded. Trauma discussion for session 3 was deemed to include one trauma section beginning at C91, ending at T269. There were 178 total therapist-participant talk-turns within session 3's trauma discussion section; and of these, 153 responses were coded (85.96% of the trauma discussion). Outside the trauma discussion section in session 3, there were 100 therapist-participant talk turns, and 50 of these were coded within the NTDS (50%). This means that 64.03% of the session was considered to be TDS, whereas 35.97% of the session was considered NTDS. Of the

A further breakdown of this information includes the types of responses found in session 3, separated by type of discussion. Of the full coded session (FCS) coded responses, 67% were coded as neutral, 19.21% were coded in a positive direction, 9.85%

were coded in the negative direction, 2.96% were considered missed opportunities, and 0.99% contained clinical language. In regards to the trauma discussion sections (TDS) in particular, 52.8% of the codes were considered neutral, 19.1% of the codes were coded in the negative direction, 19.64% were coded as positive, 14.28% were considered to be missed opportunities, and 3.57% contained clinical language. Among NTDS, 84% of responses were considered neutral codes, 10% were considered positive codes, 2% were considered negative codes, 2% were considered missed opportunities, and 2% contained clinical language.

Neutral responses. Out of the total of 153 codes within the trauma discussion section in session 3, *Neutral Responses* were coded most often (94 codes; 52.8% of coded responses) and were the most common code in all of session 1, despite whether trauma was being discussed or not (NTDS 42 codes, 84% of coded responses). In the full session, 136 of the 116 total codes classified as a neutral response (67% of codes). Examples of the types of neutral responses that the session 3 therapist-participant gave included the overall most frequently coded response, *Clarifying Questions* (NEU1; TDS: 74 codes, 48.37% of codes), and 2nd most commonly coded response (out of 10), *Reflections/Summary* statements, (NEU2; TDS: 20 codes, 13.07% of codes).

Clarifying questions. The code NEU1 occurred regularly, 74 times, within the trauma discussion section, and occurred 35 additional times outside of trauma discussion. An example within TDS included a sequence in which the client participant shared her concerns and worries about her younger sisters staying at home with her family without her (C101-103),

Yea. They called me the very next day, so I'm kinda okay, you know, with my parents and my grandma is there, you know, its just kinda mean but at the same time she take care of them better than my mom... So anything better than my mom, so it's kinda... A little better, but yeah, they say they're okay. You know, they kinda comfort me a little bit so...

The therapist-participant utilized a series of factual clarifying questions in T104-T112 in response to the client's discussion above (C101-103):

T104: Are they with your adopted parents too?... (C104: uh-huh)... T105: Did you say they all live at home together?... (C105: yea, yea)... T106: So how do they know each other? I know they live near your, your biological mom and your adopted parents... (C106: That's right)... T108: Are they, they're friends?... (C108: They are. You know, actually, okay, my adopted parents are actually my mom, and she's my aunt.)... T109: Oh your adopted parents are your aunt and your uncle? (C109: uh-huh)... T110: So is it your mom's sister?... (C110: No, its, uh, its kinda confusing)... T111: Great? Is she a great aunt? (C111: Something like that)... T112: Like la hermana de su abuela, or no? (C112: Es la hermana de papa de mi mama).

Outside of the trauma discussion, clarifying question responses tended to occur in the context of Therapist-Participant 3 clarifying Client-Participant 3's answers on a likert style symptom scale. Examples were seen in T16, "okay okay so, so, so this past, so lately none right?" when the therapist clarified a previous question regarding the client's disposable income (to figure out the fee for session), and T25, "Is that what you're

saying? Much? Or ‘I do not feel sad’?’ when the Therapist-Participant 3 attempted to clarify the client’s answers on the scale at the beginning of the session.

Reflections/summaries. The code NEU2 occurred 20 times within trauma discussion, and occurred 7 additional times outside of the trauma discussion section. Examples within TDS included T136, when the therapist-participant reflected, “It sounds like you’ve been feeling, like you said, better, but you’re kind of handling it. Still a little down.”

Examples outside the TDS again tended to occur within the context of the therapist-participant reviewing a symptom scale with the client verbally, for example in T45, the therapist-participant reviewed a question from the scale: “Okay. ‘I don’t feel particularly guilty,’ ‘I feel guilty over many things I have done or should have done,’ ‘I feel quite guilty most of the time,’ ‘I feel guilty all of the time.’” The client-participant then answered in C44, “Well I don’t think I feel guilty,” and the therapist-participant responded with a reflection/summary, T45: “Okay so you don’t feel guilty. Okay.”

Positive responses. Out of the total of 153 codes within the trauma discussion section in session 3, *Positive Responses* were coded second most often (34 codes; 22.22% of coded responses) and were also the second most common code in all of session 3, despite whether trauma was being discussed or not. In the full session, 39 out of 203 coded responses fell in the positive category (19.21% of codes). Examples of the types of positive responses that the session 3 therapist-participant utilized included *Validating Responses*, (POS1; 20 codes, 13.07% of TDS codes) and *Supportive Responses*, (POS2; 14 codes, 9.15% of TDS codes). *Empathic Responses* (POS3) were not utilized at all by the therapist-participant in session 1 TDS or FCS.

Validating responses. The therapist-participant in session 3 responded in a validating way 20 times within the trauma discussion section (153 total talk turns).

Validating Responses (POS1) occurred 2 additional times outside of trauma discussion.

Examples within TDS included the therapist-participant showing understanding of the client's experience of being upset with her mom after her mom took her younger sisters away with her, and left some of their belongings behind, described in T147-T148,

Well its understandable because she's I mean, she's done terrible thing after terrible thing to you and your family... And so of course in this situation, its like you, your sisters are, you know you're older than them, you have like almost a mom role with them and so, you obviously love them, you want to take care of them, and that she has the power to take them away and then, the thing about leaving the clothes, its like, it must hurt, because you're saying you left her things and then you're thinking about somebody else that's not your own child.

An example outside of the TDS included the therapist's use of a complex reflection in T53, "So it looks like you're like so this is like, this your symptoms seem to be a lot better than they were a few weeks ago" in response to the client-participant updating clinician about symptoms.

Supportive responses. The code POS2 occurred 14 times within trauma discussion, and occurred 3 additional times outside of the trauma discussion sections. An example of an encouraging POS2 within the TDS included T152, "What do you mean? What happened?" as the therapist-clinician encouraged the client to speak further about the traumatic experience. Additionally, an example where the clinician empowered the client was in T252, "... But [name of client], what I'm trying to say is, that not everybody

can still get through all those things the way you got through them,” and That’s what’s so amazing and great about you.” Another example within the TDS occurred at T263, when the therapist said, “I just want to say, I know it’s really hard for you to talk about those things today and I’m really glad that you did and I’m really proud of you for saying them.” An example outside of the TDS was cited when the therapist encouraged the client to talk about her symptoms and empowered her in T38, “That’s a lot better.”

Empathic responses. The therapist-participant in session 3 did not utilize *Empathic Responses* (POS3) at all during the session, either in trauma discussion sections, or in non trauma discussion sections.

Negative responses. The least common category found in session 3 was that of *Negative Responses*. Of the total of 153 codes within the trauma discussion section in session 3, *Negative Responses* accounted for 19 codes; 12.42% of TDS coded responses) and were also the least common code in all of session 3, despite whether trauma was being discussed or not. In the full session, 20 of the 203 total codes classified as a negative response (9.85% of codes). Each of the three types of negative responses were found in session 3. The *Unempathetic Responses* (NEG3) category was classified as the third most frequently coded response in session 3 despite whether trauma was being discussed or not (TDS: 14 codes, 9.15% of TDS codes). *Invalidating Responses* (NEG1) occurred only 3 times each in the TDS and FCS (TDS: 1.96% of codes). The least frequently used negative response within the trauma discussion section of session 3 and in the overall session was the category of *Unsupportive Responses* (NEG2), which occurred only twice in both the TDS and FCS (TDS: 1.31% of codes).

Unempathetic Responses. The code NEG3 occurred regularly, 14 times, within trauma discussion sections and occurred one additional time outside of the trauma discussion. These responses tended to occur in the context of Therapist-Participant 3 being demanding of the client and/or pushing expectations on the client. Examples within TDS included the therapist-participant pushing expectations on the client at the end of the session about coming to therapy and the therapy being helpful

I think that's really good that you come [to therapy], I think it's really helpful and tell me if it is or it isn't but it seems to me that it's helpful for you to come talk about these things, hard things, and you know we can kinda work on how you feel about them now. How does that sound or how does that feel to you? (T264).

The one NEG3 that occurred outside of the trauma discussion was in T54-56 when the therapist was reviewing the likert scale type questions from the symptom screen and asked, “Yea, that sounds—okay.. ‘I don’t have any thoughts of killing myself’” to which the client replied “I haven’t” and the therapist asked, “No?” the client stated, “No,” and the therapist responded with a NEG3 response in T56, “Okay, so ‘I have thoughts of killing myself but I would not carry them out,’ so you don’t have any.” In which the therapist-participant seemed distracted and seemed to be pushing her own expectations on the survivor.

Invalidating Responses. The code NEG1 occurred only 3 times within trauma discussion, and did not occur outside of the trauma discussion section. The first coded statement within TDS included T167 when the therapist-participant responded to the client’s disclosure of a traumatic event and her related thoughts and feelings with, “It sounds like, you know, you don’t [sic], I mean I noticed you said the whole family is

crazy.” The second was T197 when the clinician stated, “Not to say that that’s the way you should handle things, cause it’s not” about something the client shared she was shameful about (fighting with her family). The last coded statement occurred in T262 when the client-participant was talking about her marital problems, and the clinician responded, “He’s [client’s husband] very special you know” to the client’s problem-focused discussion.

Unsupportive Responses. The code NEG2 occurred only 2 times within trauma discussion, and again, did not occur outside of the trauma discussion section. The first within TDS NEG2 was T168 when the therapist-participant stated, “but do you feel that you’re crazy? Do you think that’s true?” in relation to the client referencing her family as crazy. The second coded statement occurred as the client spoke about being upset with and arguing with her husband, and was categorized as unsupportive because the therapist’s response was exhibiting disbelief. In the conversation leading up to the unsupportive response in T206, the therapist-participant said,

Okay. So what about when you’re fighting with [husband’s name], have you ever felt like you’re gonna do something, I mean I know you feel like throwing things sometimes right? But do you ever, do, have you ever felt like you’re gonna hurt him, like try to hurt him? (T204)

And the client responded, C204, “No.” The therapist again asked, in T205, “No. Okay. So is it, have you ever felt out of control, like you might hurt him?” and again the client responded, C205, “No.” In T206, the therapist responded with an unsupportive response, “No. Okay, Are you sure?”

Adjunctive codes. In session 3, *Missed Opportunities* (+) were found to be the fourth most frequent code (first most frequent individual code being *Clarifying Questions* (NEU1)), across trauma discussion sections, and the fifth most frequent code for the fully coded session. In session 3's trauma discussion section, 5 *Missed Opportunities* were coded (3.27% of TDS codes), and in the full session, 6 responses were coded (2.96% of FCS codes). Only one additional + code existed outside of the trauma discussion section.

An example of missed opportunities within the trauma discussion section included T91 when the therapist missed an opportunity to explore some of the difficulties the client had alluded to while going through the likert checklist/scale, and instead responded by saying, "Okay well it looks like, you know, you're like feeling a lot better. I'm glad to see that you don't have any thoughts about hurting yourself or killing yourself." Another example of a missed opportunity within the TDS occurred in T159, after the client described in detail at time when her mother had attempted to attack her and was waiting for her in the streets. The clinician responded with a clarifying question, rather than taking the opportunity to utilize a positive response, T159, "Oh just for the police?" The one example existing outside of the TDS included T59, where the therapist-participant missed an opportunity to validate, support, or empathize with the client as she inquired about the most recent time she felt suicidal. As the client answered, C58, "Uh, I think like couple weeks ago," the therapist-participant replied, "Couple weeks ago, okay" (T59), but did not inquire further or make any further response.

The second adjunctive code, *Clinical responses* (*) was coded 2 times in the fully coded session (0.99% of all codes); 1 time during session 3 (0.65% of TDS codes) in the trauma discussion section, and once code outside of the trauma discussion section. The

coded question that occurred within the TDS was in T92, when the therapist asked, “And so what is, what’s the feeling in your body when this is happening?” as the client and therapist discussed her past traumas and how she cannot cry. The one coded statement of clinical language outside of the trauma discussion occurred in T53, when the therapist-participant used clinical language, “So it looks like you’re like, so this is like, this your symptoms seem to be a lot better than they were a few weeks ago.”

In session 3, the therapist-participant used a 72 total facilitative statements including the following: Okay (39), Right (19), Yes Yes/Si Si (7), Uh huh (2), Right right okay (2), Um (1), Oh Si (1), Mm-hmm (1). In addition to facilitative statements, the therapist-participant complimented the client a total of 14 times, including; great/good (5), compliments in the context of client being a “good person” (4), Alright, perfect (2), that’s fine, that’s okay (1), that’s so good to hear (1). There were a total of 11 instances of the therapist-participant either giving advice and/or giving opinions to the client-participant, including her opinions on how the client is caring/a good person (4), her ideas on how it is helpful for the client-participant to come to session and advice on how to make the best of sessions as practice (2), her personal opinions about the client-participant’s husband (1), and saying things like, “if you killed yourself that would be so terrible (1), that’ll be good/okay good (about client not reporting suicidal ideation), and well, that’ll be nice (1). Also noted in session 3, interruptions tended to occur quite frequently. The nature of the interruptions observed included the therapist-participant finishing the client-participant’s sentence for her while she was still speaking.

Session 4. Transcript 4 involved a female therapist and a 39-year old heterosexual married woman who had four children, and identified as being Black, American Indian,

and Caucasian. The previous team's lab observed the client's presence in the transcript to be that of someone who was forthcoming, earnest, emotionally expressive, and demonstrated a broad range of affect. The therapist-participant in session 4 described the client-participant as "alert and eager to be helpful in questioning and responding" in the intake evaluation. Client-Participant 4's stated trauma and presenting problem was that she had recently found out her guardianship daughter had likely been molested by the client's father four years ago. Client-Participant 4 also disclosed that she had been sexually molested by her paternal grandfather when she was 7 years old. The selected session 4 was an intake session, and thus it was spent gathering information related to Client-Participant 4's presenting problem mentioned above. The majority of the session was spent discussing the client-participant's distress about the potential abuse of her daughter by her father. Some time was also spent discussing her own trauma history and associated difficulties, as well as other information about her life needed for the intake evaluation.

Session 4 consisted of 184 therapist talk turns. All together, 134 responses (or 72.8% of talk turns) were coded in session 4. Trauma discussion for session 4 was deemed to include three separate sections: (a) T25-T95, (b) C106-T143, and (c) T150-T156. There were 113 total therapist-participant talk-turns within session 4's trauma discussion section, and 71 total therapist-participant talk-turns outside of the trauma discussion section in session 4. This means that 61.41% of the session was considered to be TDS, whereas only 38.59% of the session was considered NTDS. Of the 113 TDS therapist-participant talk-turns, 101 responses were coded (74.26% of the trauma discussion), and of the 71 codes in the NTDS, 33 were coded (46.48% of the NTDS).

A further breakdown of this information includes the types of responses found in session 4. Of the full coded session (FCS) coded responses, 38.8% were coded as neutral, 29.10% were coded in a positive direction, 14.93% were coded in the negative direction, 10.45% were considered missed opportunities, and 6.72% contained clinical language. In regards to the trauma discussion sections (TDS) in particular, 31.68% of the codes were considered positive, 28.71% of the codes were coded as neutral, 16.83% were coded as negative, 13.86% were considered to be missed opportunities, and 8.91% contained clinical language. Among the NTDS's 33 codes, 30.30% were considered neutral, 21.21% of codes were considered positive, and 09.09% were considered to be negative. There were no instances of missed opportunities or clinical language outside of the TDS.

Positive responses. Out of the total of 101 codes within the trauma discussion sections in session 4, *Positive Responses* were coded most often (32 codes; 31.68% of TDS coded responses). In regards to the fully coded session, 39 of the 134 total codes classified as a positive response (29.10% of codes). Examples of the types of positive responses that the session 4 therapist-participant utilized included *Validating Responses* (POS1), which occurred 21 times within trauma discussion sections (20.79% of TDS codes); *Supportive Responses* (POS2), which occurred 8 times (7.92% of all TDS codes); and *Empathic Responses* (POS3), which occurred 3 times in the TDS (2.97% of TDS codes).

Validating responses. The therapist-participant in session 4 responded in a validating way 21 times within the trauma discussion section (113 total talk turns). *Validating Responses* (POS1) occurred 4 additional times outside of trauma discussion.

Examples within TDS included the therapist's response to C46, where the client-participant continued to disclose the trauma:

You know, oh my God, so yea, they didn't want to tell me about it because we're concerned about their job you know and I basically I pretty much begged them. My grandmother's private caregiver, they told her and she kept telling them you know, you have to tell [client's name], she's got kids you never know. I mean she didn't know that it was related to one of my kids. We just thought it was some random 14 year old and he said well she's now 18 and she's living she away at school living in an apartment and she has roommates and all of those things as she was telling me this. My mind was going did he mention [guardianship daughter's name]. Did he say anything about her? And the caregiver was like that sounds kind of familiar. So then I called him to confront him about it and I you know it it turned out to be [guardianship daughter] and she is not admitting anything sexual happened, 'yes he's touched my leg, he's touched my neck, hes said things around me to make me uncomfortable.' He took her to play tennis once. And apparently that one time he took her back to his apartment in [city 1]. We live in [city 2]. He took her all the way to his apartment and you're trying to say she came on to you?

You set her up, you f*cking set her up. She's 14.

To which the therapist replied, "Yea, she's 14, there's no question about it" (T47). This was coded as positive as it showed understanding and validation in some ways, but was also coded as a missed opportunity (+), given the multiple opportunities the therapist-participant had to validate and give positive, supportive, and empathic responses throughout that talk turn. Other examples included T55, "That's a big betrayal," T75,

“Wow what a big responsibility on you,” and T86, “Too much pain to deal with.” An example of a validating response outside of the trauma discussion occurred when the client discussed how different she and her husband were. The clinician responded, “...hm, and for you, you needed someone that is that steady going” (T165).

Supportive responses. The code POS2 occurred 8 times within trauma discussion, and occurred 2 additional times outside of the trauma discussion sections. These responses tended to occur when the clinician was encouraging the client to speak about the traumatic disclosure or was empowering/encouraging the client by discussing things to work on, goals, and how the therapist and client would work through these things. Examples within TDS included the first statement of the TDS, T25, “You wanna tell me a little bit about that?,” T85, when the therapist-participant discussed using relaxation techniques, her expertise in the area, and attempted to empower client by saying, “We’ll look at all these things and we’ll purge them slowly but surely and find ways to organize them psychologically and deal with them physically, also we’re gonna, we’re gonna make it better.”

Outside of the TDS, the client discussed stress related heart palpitations, and therapist’s response in T103 was a supportive one, “Okay, we’re gonna definitely work on that.” The second example outside of the TDS occurred in T169 when the therapist-participant encouraged the client, “we will work through how that organizes how you are... So I am looking forward to getting started and I am going to let you go, because I know you have to...”

Empathic responses. The therapist-participant in session 4 used *Empathic Responses* (POS3) only 3 times within the trauma discussions, and this response occurred

1 additional time outside of the trauma discussion sections. The examples within the TDS were represented by T54, “I can never begin,” T81, “I know, I know, and it feels...,” and T136, “I can imagine...” The example that occurred outside of the TDS was T101, “I can imagine” in relation to the client’s physical response to stress and her doctors’ visits.

Neutral responses. Out of the total of 101 codes within the trauma discussion section in session 4, the *Neutral Responses* category was coded second most often (29 codes; 28.71% of TDS coded responses) and was the most common code category in all of session 4, with 52 of the 134 total responses, or 38.81%, coded as neutral. Examples of the types of neutral responses that the session 4 therapist-participant utilized included the 2nd most commonly coded TDS response (out of 10), *Reflections/Summary* statements, (NEU2; TDS: 15 codes, 14.85% of codes), and *Clarifying Questions* (NEU1; TDS: 14 codes, 13.86% of codes).

Reflections/summaries. The code NEU2 occurred 15 times within trauma discussion, and occurred 6 additional times outside of the trauma discussion sections. As the session was an intake session, some of these responses occurred in the context of the clinician attempting to reflect the information she had been given. For example, in T25, “Okay 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,” in T36 when the therapist reflected “oh okay, very recently then,” and in T37, “so he’s bragging to these nurses...” Examples outside the TDs included T104, “So you described yourself as a mut. And you’re nondenominational,” and when the client reflected/summarized “six years” (T145) as the length of the client’s marriage after the client answered the question in T144.

Clarifying questions. The code NEU1 occurred 14 times, within trauma discussion sections, and occurred 16 additional times outside of trauma discussion. Some of the responses occurred in the context of the clinician asking questions to gather information about the client's background history as part of the intake session. Within the trauma discussion specifically, the clinician used a lot of clarifying questions in order to clarify family dynamics throughout the client's explanation of the abuse. Examples within TDS included the therapist's original response to the client disclosing the traumatic event that brought her to therapy (learning of her guardianship daughter's possible molestation), "and when did this happen by the way?" (T35). Another example of a clarifying question used within the TDS was the therapist-participant's response after the client disclosed that her grandfather molested her in C39, "your grandfather your mother's father?" (T40). A third example of a clarifying question within the TDS was "And is there a history, aside from the pedophilia, of any psychiatric problems in the family that you are aware of?" (T50), which was coded as both NEU1 and NEG1. Examples outside of the TDS included things like T144, "Um how long have you been married?," T145, "And four kids, um when you did work, what did you do?," T146, "And you live with your husband and the two children right now?" and T147, "um history of substance use?"

Negative responses. Out of the total of 101 codes within the trauma discussion sections in session 4, the *Negative Response* category was coded the least frequently (17 codes; 16.83% of coded TDS responses) and was also the least common code in all of session 4, despite whether trauma was being discussed or not. Examples of the types of negative responses that the session 4 therapist-participant utilized included *Invalidating*

Responses (NEG1; TDS: 15 codes, 14.85% of TDS codes), and *Unempathetic Responses* (NEG3; TDS: 2 codes, 1.98% of TDS codes). *Unsupportive Responses* (NEG2) were not used in the trauma discussion sections of transcript 4, but were used once in the overall session (1 code; 0.75% of all codes)

Invalidating Responses. The code NEG1 occurred regularly, 15 times within trauma discussion sections. *Invalidating Responses* occurred one additional time outside of trauma discussion. Some of these codes occurred in the context of the therapist-participant conveying empathy/support for those with whom the client was discussing discomfort or being upset. An example of NEG1 occurred in T58, when the client responded “It’s her only son,” to the client expressing how frustrated she was with her grandmother for allowing her father to come to the house even with her daughter there. Another example of an invalidating response within the TDS included the therapist-participant’s response to C155, “Yea, I am actually meeting a girlfriend after this, this afternoon to, just as support for what I am going through today.. So I do, I am blessed, very blessed there” [in regards to her support system], T156, “Wonderful... then our work will be all that much easier.” Other types of invalidating responses occurred due to the nature of the intake, as the therapist-participant was attempting to get through the questions/material needed, for example in T143 when the therapist said, “um, could I ask you a couple of more questions?” as the client was attempting to continue her discussion of the traumatic event. The one invalidating response that fell outside of the trauma discussion was in response to the client saying that she wished she and her husband had better communication, T166, “Yea, well, when the time comes we can always touch on that...”

Unempathetic Responses. The code NEG3 occurred only twice within trauma discussions, and also occurred one other time, outside of the trauma discussion sections. Once example of NEG3 occurred in T155, and was coded because the therapist-participant appeared distracted. The talk turn was comprised of the therapist speaking about one topic, (schizophrenia and marijuana) and in the next thought saying, “yeah.. um.. okay,” and then she changed the topic to something unrelated (the client’s social support system). The one example of this outside of the TDS occurred in T158 when the therapist-participant again appeared distracted and changed the topic from T157 to T158, “alright.... I think that from the story... I think that I have gotten actually everything that I need... so it is just the nuts and bolts stuff...”

Unsupportive Responses. The code NEG2 were not coded in the trauma discussion section of transcript 4, but there was one response outside of the trauma discussion bounds that was coded as unsupportive, NEG2 was coded when the therapist participant reacted in disbelief to the client’s response about her substance use history, and continued to ask the question though the client had answered “No” multiple times (T146-T148).

Adjunctive codes. In session 4, specifically within trauma discussion sections, responses that included a *Missed Opportunity* (+) occurred 14 times (13.86% of TDS codes). Among trauma discussion sections in session 4, this code was the third most coded individual response. No additional instances of missed opportunity codes existed outside of trauma discussion sections. These responses tended to be coded in addition to neutral or negative responses as the therapist-participant usually had an opportunity to add something positive. An example of this code attached to a neutral response was

shared earlier from T47 when the therapist had an opportunity to utilize positive responses more frequently as the client described the traumatic event she was currently dealing with. Other examples occurred in T49, when the therapist responded with a clarifying question but did not validate, support or empathize with the client, “So she’s not your child or your husband’s,” and T51, when the same occurred, “um the grandfather?” This code also occurred adjunctively to negative codes, such as in T59, “Yea I hear you on that and just the way you um sort of described your grandmother I can feel from that what she must have.”

Clinical responses (*) were found to be the fourth most frequent individual code in the trauma discussion sections and were utilized mostly as an adjunctive code to an existing coded response as well. The therapist-participant in session 4 utilized 9 *Clinical* responses (8.91% of TDS codes). No additional instances of clinically coded responses existed outside of trauma discussion sections. An example occurred in T114- T115,

Yea well because we learn from our experiences and we make adjustment to our behaviors based on those experiences and your experiences have have not really.... Been so positive so your responses are adaptive to the environment you have had been in the past. Problems arise when they are no longer adaptive in the present what I think you are more experiencing is just pure pain of the new opening of the wound.

Another example occurred in T152-153 and T155,

Yea... Well, it is like all mental health problems, but schizophrenia does have its own specific genetic component. It sounds like there might be some substance abuse there to... if the aunt used substances that can... Yea because it is like a

physical stressor for the body, then the body has to equilibrate after and go.. oh and then get the equilibrium and all those body systems have to go okay lets get back. If you do that too often... then... not to mention psychological too much substance abuse developmentally takes you off the learning trajectory, learning to adapt to stressors and learning coping mechanisms and how to turn to your environment and learn to grow... but you know if you just get stoned, you didn't learn that... you know you cant work on that... No but schizophrenia is more of an intense, genetic sort of biological predisposed condition that tends to be a problem..

In session 4, the therapist-participant utilized 52 total facilitative statements including the following; Okay (12), Yea (11), Right (8) oh right right (4), Interesting (4), Sure (3), Umhmm (3), Oh yea ok (2), Alright (1), oh my goodness (1), wow (1), ahh (1) uh huh, exactly (1). In addition to facilitative statements, the therapist-participant complimented the client a total of 7 times, including; that's wonderful (2), How wonderful (1), nice (1), that would be great (1), yes good point (1), oh, my pleasure (1). The therapist-participant gave her opinion three times in transcript 4: that's very important (1), Not uncommon to have symptoms that might affect you (1), kids are funny, they're resilient as hell and it's not until something comes up that you can tell that you were the caretaker for yourself when you were a kid (1).

Session 5. Transcript 5 involved a female therapist and a 28 year-old, heterosexual, Caucasian client-participant who identified as Protestant and had two children. The previous team's lab observed the client's presence to be that of someone who spoke slowly, expressed minimal emotion throughout the session, and presented

with a dry sense of humor. Therapist-Participant 5 described the client-participant as “extremely intelligent” in the intake evaluation, and noted that the client-participant “often smirked” when discussing painful past events. Client-Participant 5’s trauma included a history of childhood sexual abuse, by a neighbor, which lasted several years, sexual abuse by her father, and neglect from her mother. The session used for this study involved discussions about the client-participant’s history of abuse and neglect, and her current interpersonal difficulties.

Session 5 consisted of 301 therapist talk turns, with 103 responses (or 34.22% of talk turns) coded. Trauma discussion/disclosure in session 5 was deemed to include one section, beginning at T148 and ending at T290. There were 142 total therapist-participant talk-turns within session 5’s trauma discussion section and 159 therapist-participant talk turns outside of the trauma discussion in session 5. This means that 47.18% of the session was considered to be TDS, whereas 52.82% was considered to be NTDS. Of the 142 total therapist-participant talk-turns within session 5’s trauma discussion section, and of these, 67 responses were coded (47.18% of the trauma discussion). Of the 159 NTDS talk turns, only 36 were coded (22.64% of NTDS).

A further breakdown of this information includes the types of responses found in session 5 (e.g., Positive, Negative, Neutral) separated out by type of discussion (i.e., FCS, TDS, NTDS). Of the full coded session (FCS) coded responses, 49.51% were coded as neutral, 26.21% were coded in a positive direction, 14.56% were considered missed opportunities, 7.77% were coded in the negative direction, and 1.94% contained clinical language. In regards to the trauma discussion section (TDS) in particular, 50.75% were coded as neutral, 23.88% were coded as positive, 17.91% were coded as missed

opportunities, 5.97% were coded as negative, and 1.49% were coded as clinical. Among the NTDS's 36 codes, 47.22% were neutral, 30.55% were positive, 11.11% were negative, 8.33% were missed opportunities, and 2.77% were clinical.

Neutral responses. Out of the total of 67 codes within the trauma discussion sections in session 5, the *Neutral Responses* category was coded most often (34 codes; 50.75% of TDS coded responses). Similarly, in the full session, the *Neutral Responses* category was also the most common code category in all of session 5, with 51 of the 103 total responses, or 49.51%, coded as neutral. Examples of the types of neutral responses that the session 5 therapist-participant utilized included the most commonly coded TDS response (out of 10), *Clarifying Questions* (NEU1; TDS: 22 codes, 32.84% of codes), and *Reflections/Summary* statements, (NEU2; TDS: 12 codes, 17.91% of codes).

Clarifying questions. The code NEU1 occurred 22 times, within trauma discussion sections, and occurred 17 additional times outside of trauma discussion. Examples within TDS included the therapist-participant's response to C173, "Especially since um I kinda slightly turned their car around before letting them find out I was there," which was T174, "You turned their car around?." Additionally when the client was speaking about some of the trauma directly, "Well if you wanted to go to the bathroom, it's a good idea if she's outside because if not she'll come watch you and then yell at you if you use too much toilet paper" (C187), Therapist-Participant 5 used clarifying questions as the response such as in T188 and T189, "That happened often?" and "How much were you allowed to use?" This continued in the response to the client disclosing more about the trauma, "Or if you wanted food 'cause you were hungry, she had to be far enough away that you didn't get caught" (C193), to which the therapist replied, "Were

you not allowed to eat what you wanted?” Examples outside the TDS included, T2, “The what copy?,” C2, “The rough copy,” T30, “You told him you appreciated it?,” and T37, “So he owns property?”

Reflections/summaries. The code NEU2 occurred 12 times within trauma discussion, and did not occur outside of the trauma discussion sections. An example within TDS included the talk turns that comprised C208-T209. The client-participant was disclosing some of the things that her mom would do to her as a child, including, “Oh I did the family laundry starting when I was almost six. I actually did it before then but I did all of it after that. Um my brother mostly did the dishes,” and the therapist replied, “Surprising that you could reach to do the laundry” as a simple reflection/summary. The therapist also summarized the discussion by saying, “at a very um, in addition to the sexual abuse you went through, you also have a very abusive relationship with both of your parents” in T224. Additionally when speaking about the sexual abuse specifically, the therapist reflected, “I know that you said that before that you felt like you’re watching it happen” (T262).

Positive responses. *Positive Responses* were coded second most often 162 codes; 23.88% of TDS coded responses) and the *Positive Response* category was coded second most often within the fully coded session with 27 of the 103 total codes classified as a positive response (26.21% of codes). Examples of the types of positive responses that the session 5 therapist-participant utilized included *Validating Responses* (POS1), which occurred 12 times within trauma discussion sections (17.91% of TDS codes); *Supportive Responses* (POS2), which occurred 3 times (4.48% of all TDS codes) and *Empathic Responses* (POS3), which occurred 1 time in the TDS (1.49% of TDS codes).

Validating responses. The therapist-participant in session 5 responded in a validating way 12 times within the trauma discussion section (67 total talk turns). *Validating Responses* (POS1) occurred 6 additional times outside of trauma discussion. Examples within TDS included T178 when the therapist showed understanding of the client's past and perspective, "You liked to kind of play around with adults that you, when you were younger huh?," and on the same topic later on, the clinician stated, "It makes sense why you started playing with theirs when you got older" (T233), in response to the client-participant having spoken about her parents saying, "cause that's it is not fair to play with brains that you love" (C232). Another example within the TDS was T272 when the clinician said, "it is extremely, extremely traumatizing" in response to the client sharing about her sexual abuse.

An example outside of the TDS included when the therapist validated the client sharing that her husband is "just her husband," with "Right and that's only part of your life" (T20). She continued to use positive responses when she used a complex reflection to continue to talk about the subject in T115-T117, "you're also trying to start depending on him because he's coming back and changing... yet he takes little steps back ...at certain points"

Supportive Responses. The code POS2 occurred 3 times within trauma discussion, and occurred 4 additional times outside of the trauma discussion sections. The statements within the TDS were: T152, "That's a good power to have," which was empowering a client strength; T270, supportive of the client as she shared about her sexual abuse, "That was because you were so young and small;" and T289, "Well I wanted to thank you for sharing that with me." The examples outside the TDS were: T32, "I'm hoping he

continues to surprise you,” T33, “I’m sure coming into therapy will bring up a lot of things,” and T42 and T132, “Tell me about that.”

Empathic responses. The therapist-participant in session 5 used *Empathic Responses* (POS3) only once within the trauma discussion, and this response occurred 1 additional time outside of the trauma discussion sections. The POS3 statement within the TDS occurred at T216 when the therapist empathized, “I’m sure that felt very unsafe for you,” in relation to the client speaking about her mother playing mind games with her as a child. The coded comment outside the TDS was T117, “I’m sure it is hard to, to allow you to fully trust him” as the client discussed her and her husband’s relationship.

Negative responses. Out of the total of 67 codes within the trauma discussion sections in session 5, the *Negative Response* category was coded the least frequently (4 codes; 5.97% of coded TDS responses) and was also the least common code in all of session 5, despite whether trauma was being discussed or not. In the full session, 8 of the 103 total codes classified as a negative response (7.77% of codes). Examples of the types of negative responses that the session 5 therapist-participant utilized, included *Invalidating Responses* (NEG1; TDS: 2 codes, 2.99% of TDS codes), and *Unempathetic Responses* (NEG3; TDS: 2 codes, 2.99% of TDS codes). *Unsupportive Responses* (NEG2) were not used in the trauma discussion sections of transcript 5, but was coded once in the overall session (1 code; 0.97% of all codes).

Invalidating responses. The code NEG1 occurred only 1 time within the trauma discussion section. *Invalidating Responses* occurred 4 additional times outside of trauma discussion. These responses tended to occur in the context of the therapist-participant asking inappropriate questions of the client. For the one TD NEG1 in T267, the therapist

spontaneously changed the course of the discussion from the client's nightmares to the following question about the client's childhood sexual abuse:

I wanted to ask you, if you don't feel comfortable telling me that's fine, but um, it was kind of insinuated, in the um, you know what I'm talking about, what happened that there was a knife involved?

The client-participant responded in C267-268, "I don't know that it was a knife, um," and the therapist asked, "or a sharp object?" (T269).. "That was because you were so young and small... and so in a sense, he made it work" (T270-271).

The NEG1 responses outside of the TDS included the therapist being dismissive in T290 (the direct talk-turn after the trauma discussion finished in T289), "Yea and Um, I wanted maybe to stop a little bit early, I have some, every five weeks we give our clients' um some sheets just to reevaluate what's going on..." as well as being dismissive and inappropriate in T299-301, "okay well let's go outside, let me get you those sheets, and I will look over this [a spreadsheet the client had made her], This is really insane [in reference to the spreadsheet]," "This is really crazy" The final invalidating response outside the TDS occurred in T293, when the therapist was being judgmental of the client, "You didn't have a fridge?"

Unempathetic responses. The code NEG3 occurred only twice within the trauma discussion, and were not coded any additional times outside of the trauma discussion sections. The first unempathetic response occurred in T258 as the therapist-participant brought up the client's written account of her sexual abuse as a child; she stated, "because I when we talk about it, you kind of talk around it, but you haven't really told me the detail that was written in there." The second NEG3 occurred as the client was talking

about how she dissociated during the trauma. The therapist-participant reflected that the client had previously discussed feeling like she was watching the sexual abuse happen, the client responded, “Yea. It. It wasn’t me and I don’t want to go there because I don’t know if I can” (C262). The therapist-participant responded with the unempathetic response, “You don’t want to go to the actual experience?”(T263), to which the client replied, “it, it, yea. I don’t know what would happen, there’s nowhere in this world that’s safe” (C263).

Unsupportive responses. The code NEG2 was not coded in the trauma discussion section of transcript 5, but there was one response outside of the trauma discussion bounds that was coded as unsupportive. This response occurred at T35, when the therapist stated, “how is that possible?” which conveyed disbelief of the client’s previous statement about her husband, “He doesn’t have a job right now. He has income, but he doesn’t have a job” (C34).

Adjunctive codes. In session 5, specifically within trauma discussion sections, responses that included a *Missed Opportunity* (+) occurred 12 times (17.91% of TDS codes). Among trauma discussion sections in session 5, this code was tied for the second most coded individual response (first most frequent individual code was *Clarifying Questions* (NEU1)). Three additional instances of missed opportunity codes existed outside of trauma discussion sections. Examples of this code included, T263, which was just explored above as an example of an unempathetic response; the code was also coded as a missed opportunity since the clinician could have utilized a positive response here to support, validate, or empathize with the client. Additionally, examples of clarifying question responses, negative, or neutral responses tended to have a missed opportunities

code attached, such as the clarifying questions asked as the client shared her trauma, “What is the nature of your relationship right now?” “How did it go over her head?” (T245), and “Which is what? (T247), were some examples. The same was true for non trauma discussion sections.

Clinical responses (*) were utilized mostly as an adjunctive code to an existing coded response as well. The therapist-participant in session 5 utilized 1 *Clinical* response (1.49% of TDS codes). One additional instance of clinically coded responses existed outside of trauma discussion sections. The TDS * included T277- 278, “It’s the body’s way of protecting, protecting itself... It seems like you only really physically experience the trauma, but when you’re having your nightmare you said you were shaking and...” The coded statements outside the trauma discussion were T110-T112:

I mean it sounds like you are having an interesting experience right now because you’re at this point in your life where you’re having this corrective emotional experience from your childhood. You’re almost re-experiencing a secure childhood in which you have a support system and you’re feeling more stable and you’re feeling safe. So you’re almost kind of going through your childhood phase and then you also are having all this responsibility so you also have this other role of being an adult who... and having to make and having to, you know, initiate all these things... taking care of things is because lets say your husband doesn’t.

In session 5, the therapist-participant utilized 211 total facilitative statements including the following; Mhmm-hmm (176), Right (15), Yea (10), Ok (8), Oh my goodness (1), and uh huh (1). In addition to facilitative statements, the therapist-participant complimented the client a total of 5 times, including; you did it so organized

(1), wow this is unbelievable (1), that's a good line, I think I'm going to use that (1), that's a good power to have (1), that's smart (1). The therapist-participant gave her opinion or advice three times in transcript 5 as well: That's usually what the feeling is (1), That's very interesting (1), Okay so I'm excited that's gonna get underway (1).

Chapter IV. Discussion

As noted in the introduction section, extant research asserts that the response to a survivor's discussion of trauma may be influential in that survivor's trauma recovery trajectory (Brewin et al., 2000; Hong et al., 2011; Krause et al., 2003; Pruitt & Zoellner, 2008; Rieck et al., 2005; Shenk & Fruzzetti, 2011; Sorsoli, 2009), especially when the responder is a therapist. Based on the existing literature, this researcher categorized such responses into positive, negative, and neutral types; positive responses to traumatic discussion have been shown to positively influence an individual, whereas negative or neutral/no-response responses have been shown to negatively influence a survivor. Literature across psychotherapeutic domains, perspectives, and theories each agree that the major tenets of positive responses to traumatic discussion include the common factors vital in all therapeutic exchanges; validation, acceptance/being non-judgmental, supportive, and empathic. Despite the fact that current trainees have the foundations and skills to be able to utilize such approaches when responding to trauma survivors, trainee therapists appear to lack knowledge about how to respond to a client's discussion of trauma in session (Read et al., 2007).

Given the potential gaps in research and training, this study sought to explore trainee therapist responses to the discussion of trauma in therapy using a unique methodology in this literature. The researcher created a comprehensive coding system based on the existing literature regarding responses to traumatic discussion, implemented a deductive coding system, and then employed a qualitative content analysis to examine the coded verbal responses to five clients' discussions of trauma during psychotherapy sessions as compared to responses during non-trauma discussions.

Accordingly, this chapter begins with a discussion of the coded trainee therapist responses to trauma and non-trauma discussions by survivors, highlighting patterns found in the results, both within and across participants, in context of relevant literature. Although findings from the present study are difficult to compare with nearly all previous research on therapist responses to trauma discussion given the mismatch between methodologies, populations studied, and research questions (i.e., interviews with clients who had sought professional help in dealing with trauma, research about non-professional listeners' reactions to the discussion of trauma, and research focusing mainly on specific types of trauma such as childhood sexual abuse, emotional abuse, or physical violence, though rarely any research on integrated, diverse trauma experiences), comparisons of the results to the extant literature, when appropriate, are made in this chapter.

More specifically, this chapter starts by reporting patterns found that included: (a) overall patterns related to frequency distributions across sessions; (b) the prevalence of neutral responses within and across sessions, specifically preferences for data driven exploration versus affectively driven exploration, closed-ended versus open-ended questions, and simple versus complex reflections; (c) the presence of negative codes in sessions, specifically discussions concerning action driven versus listening behaviors by trainees and the implications of high frequencies of negative responses; and (d) the lower prevalence of positive responses within some sessions, when compared to neutral and negative responses in those same sessions, specifically validation and supportive responses as compared with empathic type responses. Next, patterns among adjunctive data and facilitative responses, as well as the decision process surrounding discussions of trauma are discussed. 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 are shared.

General Frequency Distribution Patterns Related to Trainee Therapist Responses

General findings within and across sessions indicated that therapist-participants responded in both negative and positive, and additionally in neutral ways. These results are similar to one study in the existing literature that interviewed client-participants who had worked with mental health professionals without specialized trauma training. Though the study did not look at frequency of responses, the results did contain frequency rates of clients who reported certain interventions as being most helpful. In the study, Palmer et al. (2001) found that clients said that therapists tended to react in both positive and negative ways to clients who disclosed trauma, but the study did not specify which occurred more frequently.

In contrast to Palmer et al. who did not report neutral responses, the overall results from the present study indicated that neutral responses were the most commonly occurring response across all five fully coded sessions and all talk turns (this finding is discussed in more detail in the next section). The same pattern of distribution was found when comparing the full session (FCS) overall frequency distribution, to the frequency distributions in trauma discussion sections (TDS) and non-trauma discussion sections (NTDS); patterns existed in the order of highest to lowest, as neutral, positive, and negative responses.

Yet, when looking at individual transcripts in the TDS, some differences were found in relation to patterns of frequency. In all of the trauma discussion transcripts, neutral responses were the most common, except for in transcript 4. In the TDS of

transcript 4, a unique frequency pattern of positive, neutral, negative was observed. In contrast, the distribution for the remaining four transcripts included neutral as the most common code category, with a split between listeners responding positively as the second most frequent category or negatively as the second most frequent category, as hypothesized in previous research studies that focused on responses from individuals without specialized training in trauma (Josephson & Fong-Beyette, 1987; McGregor, Thomas, & Read, 2006; Palmer et al., 2001). Specifically, the remaining patterns were either neutral, positive, negative patterns, as seen in sessions 3 and 5; or neutral, negative, positive patterns, as seen in sessions 1 and 2. As the interest and focus of this study is to examine and highlight the TDS patterns and responses, the remaining discussion regarding results and findings, will be related to trauma discussion in particular, and will at times be compared to NTD.

Results Patterns Related to Neutral Responding

Historically, past researchers have focused on categorizing responses to trauma discussion by therapists as either positive or negative (Shenk & Fruzzetti, 2011). However, this system of categorization tended to leave out what could be deemed as “neutral” responses or “no response” categories, which are valuable to consider given Pruitt and Zoellner’s (2008) findings that they may negatively impact survivors in the long term. Thus, as stated in the methods section, this researcher originally included non-responses in her NEG-1 code before creating a neutral category.

Subsequently, a new separate category was created during the pilot coding process given the high prevalence of clarifying questions and simple reflections that emerged, which seemed noteworthy to explore (e.g., would they be more “neutral” in

nature than ignoring a client's trauma disclosure?). Our research supports the need to continue considering "neutral" responses in future research because, as noted previously, the overall results from the present study indicated that neutral responses were the most commonly occurring response across all five fully coded sessions and all talk turns. Neutral responses, categorized into either Clarifying Questions (NEU1), or Reflection/Summary statements (NEU2), comprised 49.46% of all codes (30.10% of TD; 17.49% of NTD). Because clarifying questions (NEU1) occurred more frequently (74%) than reflection/summary statements (NEU2; 26%) among neutral codes in trauma discussion sections, they are discussed in that order next.

Clarifying questions (NEU1). When examining data regarding clarifying questions (NEU1), this study noted that this code had the highest prevalence of individual codes when comparing all codes across all five sessions within the TDS. Specifically, NEU1 codes occurred 2.3 times more often than the next most frequently occurring code, validating responses ($n = 156 / n = 68$). Some patterns that were found within the category of *Clarifying Question* type neutral responses are discussed below.

Data driven versus affect driven neutral responses. One pattern found throughout the results included the observation that therapists tended to respond to clients' trauma by obtaining factual, data driven information, more often than emotional or affectively driven information. This finding was seen specifically when looking at the neutral code subtype of *Clarifying Questions* (NEU1), coded when the therapist used a question format to clarify something the client had said previously. This finding is consistent both with literature that suggests that novice clinicians may prioritize gathering and obtaining factual information over emotionally connecting with clients to process

their traumatic experience, as well as literature that suggests that trainee therapists might lack specific understanding around how to utilize questions to facilitate therapeutic goals (James & Morse, 2007; Zoellner et al., 2011).

For example, this phenomenon occurred in Transcript 5 when the clinician focused on data driven factual information, versus taking an opportunity to emotionally connect with the client, in the following excerpt in which the client began by talking about her abusive mother:

C187: Well, if you wanted to go to the bathroom, it's a good idea if she's outside because if not she'll come watch you and then yell at you if you use too much toilet paper T188: That happened often? C: 188 Yea, pretty much. T189: How much were you allowed to use? C189: Two pieces, one if you only went pee.

The same process of gathering information was seen in Transcript 3, when the client in C152-153 talked about her mom trying to stab her. The clinician responded with the question, "How old were you?" (T154).

This phenomenon appears to be consistent with Read et al. (2007)'s point that, "clinicians may feel under pressure to gather all the details, or try to fix the 'problem' immediately, or both" (p. 109) when facing decisions about how to respond to trauma discussion. Clinicians might also feel uncomfortable with the topic and change the subject to something more concrete and less intense than emotional or trauma related material, such as fact gathering; an example of which is seen here from Transcript 2:

C10: And, um part of this whole operation is I am not scared of the operation, which is something I probably wouldn't have said a couple of years ago. I would have been terrified of having an operation. But I am terrified of the outcome. T10:

Is it in two days? C12: Yea, it is not a major dramatic operation. It's something that is very run of the mill for them, but... its my eye...T12: Yes C13: It's my life. T13: Now is it inpatient or outpatient?

Closed versus open-ended neutral responses. Another pattern found in the trauma discussion sections across all five sessions, specifically related to *Clarifying Questions* (NEU1), was that the questions asked tended to be of a closed-ended nature ($n = 124$), rather than an open-ended nature ($n = 32$). While this phenomenon might be explained by the nature of clarifying questions themselves, it is of note that clarifying questions can be asked both in open-ended, as well as closed-ended ways. In the extant literature on open-ended versus closed ended-questions, Miller and Rollnick (2012) noted that closed-ended questions might feel leading, and give little opportunity for clients to feel comfortable to openly discuss information that was not targeted via the closed-ended question.

While the occurrences were not as often as closed-ended questions, the therapist-participants in this study also utilized open-ended questions at times, such as “What’s the feeling in your body when that’s happening?,” (T92; session 3). Miller and Rollnick (2012) support the idea that the use of such questions in a therapeutic situation can provide clients with an opportunity to express their experience, perspective, and be more inclined to elaborate or discuss the situation with more depth. For example, after the therapist asked the open question, “What is the nature of your relationship right now?” (T242; Session 5), the client responded in a way that exhibited depth, C242-244,

“Well considering that she is absolutely clueless I would say it’s pretty good...She has no idea that I’m not the person that she decided I was going to be

sometime very early on in my life... and I, last time she was out here I kind of tried to introduce myself and that went right over her head too.”

Additional examples of closed ended versus open ended questions in the present study included things like the session 3 therapist having asked “And you don’t feel that way?” (T169), versus “How do you feel?,” and “Why do you think you don’t feel that way?” (T170) versus “Can you tell me more about your feelings and thoughts?” This study also observed that certain uses of closed ended questions might convey suggested feelings, assumptions, or judgments, and can potentially turn into a negative interaction between client and therapist. This process was observed in session 1, T92-T94, when the therapist asked,

T92: But like, how about sexually, has that impacted you sexually? C92: Not that I know of. T93: Like do you feel like you need to be more in control when you’re having...C93: No, I don’t. T94: Okay. C94: Yea, no I don’t.

The interaction turned to a negative response at T95, when the therapist continued on with the same topic. The way in which the therapist discussed the topic seemed leading, through closed ended questioning and made the therapist seem pushy, which inadvertently conveyed the therapist’s own beliefs about the situation to the client, and in this case, ignored the client’s responses. Instead, the use of open ended questions in this scenario, such as, “Sometimes, clients find that experiences like these impact their life in many ways. What type of an impact has this trauma had on your personal life or relationships?” would allow the client more space, more control in the response, and not convey therapist assumptions in the same way as the above example (T92-T95).

The use of open ended questions in therapy, especially in early stages of treatment, can help therapists and clients build a strong therapeutic alliance (Sommers-Flanagan & Sommers-Flanagan, 2008). As known from the trauma literature, having a strong therapeutic alliance can, at minimum, provide a variety of benefits such as, decreased treatment drop-out and more reliable session attendance, less avoidance and greater disclosure of personal material, greater treatment adherence and medical compliance, greater openness to-and acceptance of-therapist interpretations, suggestions and support, and more capacity to tolerate painful thoughts and feelings during therapeutic exposure to trauma memories (Briere & Scott, 2012). Due to the fact that the present study did not utilize measuring of therapist alliance, the therapeutic alliance cannot be commented on in relation to the current research; however, future research might focus on the relationship between clarifying questions (open ended versus closed ended) as compared to the working alliance inventory filled out by clients during the therapeutic process.

Within session difference – session 3. When comparing individual session TDSs to one another, the present study found a unique finding regarding Session 3's NEU1 data. Out of all five TDSs, session 3 had the most occurrences of clarifying questions ($n = 74$), over two times more than the next most frequent session, Session 2 ($n = 35$). Session 5 ($n = 22$), session 4 ($n = 14$) and session 1 ($n = 11$), all fell within a similar range of frequencies. Across overall sessions, the pattern was similar. Session 3 had the most clarifying questions by 2.79 times; however, the rest of the pattern existed in a different order from the TDS, revealing similar numbers of clarifying questions across sessions (session 5, $n = 39$; session 2, $n = 36$; session 1, $n = 34$; and session 4, $n = 31$).

It should be considered that part of session 3 included a verbal review with the client of a symptom scale, which may account for the large number of NEU1 codes. Specifically, the clinician began the session by asking clarifying questions about each individual question on the questionnaire form, which added up to 109 instances of clarifying questions across the total session. However, as noted above, even when looking only at trauma discussion sections after the likert-questionnaire was finished, the therapist-participant in session 3 still asked 74 clarifying questions. Additionally, out of the 74 questions in session 3's TDS, 68 of them were closed ended, while only 4 were open-ended. Given the nature of closed ended questions, they might elicit further questioning, given that they pull for one-word answers. Therefore the therapist in this situation might have had to ask more questions than other therapists who used open-ended questions, if she wanted to gather information about the client or situation.

When examining the TDS data more closely, it seems as though the therapist in session 3 attempted to use a Socratic Questioning technique from the CBT literature, to have the client examine her thought processes. The use of such a technique likely also added to the higher number of questions in this transcript when compared with the other therapist-participants. The purpose of this discussion is not meant to criticize the technique of the therapist; however, the technique may not have been as helpful as the therapist had intended in this particular case. Beck notes that Socratic questions should be collaborative, and be “phrased in such a way that they stimulate thought and increase awareness, rather than requiring a correct answer” (Beck, 1993, p. 103). In his examples, Beck discusses using open ended questions, rather than leading, closed-ended questions

to use the technique most effectively. In session 3, the therapist attempted to highlight thinking errors that the client was having about being a violent person in T195-T198:

T195: Okay so what you're saying in that, so you're saying that well first of all, in all, so in your life, your examples, the people that you saw, always used violence right? T196: So in twenty one years, one time you got really angry, you got violent and you did it in self defense, you didn't um, sounds like you didn't, she was starting a fight, you didn't just get angry and then go after someone for no reason right? T197: No to say that that's the way you should handle things because obviously it's not, but you're fourteen and you, even in that situation, you weren't, you didn't start the fight right? T198: okay so we have all this evidence right?

Another situational hypothesis proposed to help understand this finding might include that perhaps the therapist-participant's style at the beginning of the session, used when following up about the questionnaire, was simply continued into the session without awareness, or the therapist-participant's style is one of tending to ask more clarifying questions than listening. Given we were unable to gather data from the therapists, these hypotheses cannot be confirmed. Additionally, cultural factors might be relevant. The client was also Spanish-speak, therefore the therapist might have felt it necessary to clarify certain words/phrases due to language inconsistencies occurring as the client described her experience. An example of such a clarifying process occurred from T108-T112:

T108: Oh are they friends? T: 109: oh your adopted parents are your aunt and uncle?... T110: SO is it your mom's sister? C110: no, its, uh its kinda confusing

T111: Great, is she a great aunt? C111: something like that; T112: Like la hermana de su abuela, or no? C: 112: Es la hermana de papa de mi mama

It could also be hypothesized that, culturally, discussion styles including numerous questions from a mental health professional might be more acceptable/part of the cultural norm for Spanish-speaking therapists. Research might support this final hypothesis, as the literature notes that the response styles for what is efficacious among American populations have typically been applied to individualistic versus collectivistic cultures (Sin & Lyubomirsky, 2009); therefore, likely recognizing cultural differences in preferred styles of responding.

Reflection/summary statements (NEU2). The second neutral code category was comprised of Reflections/Summary statements (NEU2), which occurred third most frequently across all five trauma discussion sections ($n = 55$). As noted in the coding manual, these reflections and summary statements resembled simple (versus complex) reflections, as in they occurred only when the therapist-participant repeated back what the clients said in their own words, without reading into any additional meaning, and/or when the therapists summarized, without adding meaning, something the client-participants stated earlier in the sessions. For example, in session 2, the therapist reflected, “It reminds me of when you said, in your childhood you felt clumsy” (T98).

As previously mentioned in the literature review, the references of simple versus complex reflections from the MI literature lend themselves to the discussion of the present study’s results. When comparing simple reflections within NEU2 to more complex reflections, which were found within the POS1 Validation code of the positive category, the study’s results indicate that POS1 codes ($n = 68$), were utilized more often

than NEU2 codes ($n = 55$) across all 5 sessions in the TDS. This finding was true across all sessions, though within sessions, sessions 3 and 5 had an equal number of POS1 and NEU2 codes, rather than higher numbers of POS1 versus NEU2 like in sessions 1, 2, and 4. This same pattern was found across full sessions with POS1 having 88 codes across the five full sessions, and NEU2 having 79 codes. In the NTDS however, this pattern did not hold, and NEU2 ($n = 24$) > POS1 ($n=20$). As both the NEU2 and POS1 categories include other components in addition to reflective statements, the comparison cannot be made in specific terms, but will be discussed generally in relation to TDS results.

Therapist-participants utilized category POS1, coding of complex reflections, 1.24 times more often than the neutral category NEU2, which coded simple reflections. While both types reflections promote a strong therapeutic alliance (Briere & Scott, 2012; Farber & Hall, 2002), safety and stability in the therapeutic environment (Briere & Scott, 2012), clients feeling heard, and work to improve understanding between therapist and client (Miller & Rollnick, 2012), the same literature also suggests that clients feel a deeper sense of being heard, understood, and less resistant when complex reflections are used versus simple reflections (Miller & Rollnick, 2012). It is promising in terms of positive outcomes for trauma survivors that therapists in general in this study, tended to respond in a validating way more times than not, which will be discussed in the positive section below.

Within participant findings. Patterns that were found when looking at the NEU2 code included instances of relatively high frequencies among session 3 ($n = 20$); session 4 ($n = 15$) and session 5 ($n = 12$); with a moderate amount in transcript 2 ($n = 6$) and a low amount in transcript 1 ($n = 2$). As there is no current literature regarding the

frequency distributions of therapist responses to trauma across types of trauma, only hypotheses regarding the frequency distribution for this code can be discussed. As previously explained, the number of reflection/summary statements might have been the highest in session 3 given that the content of the session included a review of a likert-type scale the client had filled out. As the literature suggests that reflections tend to follow clarifying questions (Miller & Rollnick, 2012), the amount of clarifying questions in session 3 might have impacted the number. Additionally, while trauma discussion volume did not exist in the same frequency distribution pattern, session 3 did have the most codes within trauma discussion in general, which also might account for the high number of codes in session 3.

Similarly, session 4 was an intake session, which likely generated clarifying questions simply given the nature of gathering information via an intake or first session. In the results, reflective/summary statements within the TDS were used in the second highest frequency, again mimicking the literature, which suggests reflections tend to follow clarifying questions. Utilizing reflections during an intake or first meeting can also be beneficial in establishing a strong therapeutic alliance (Miller & Rollnick, 2012).

Conversely, the low number of NEU2 responses in sessions 1 and 2 might be explained by other hypotheses. Session 1 has the least talk turns within its trauma discussion section (109 talk turns); therefore, the low number of reflections/summaries might be proportionate to the low volume. However, this same hypothesis would not apply for session 2, given that it had the second most talk turns in a TDS, yet the second least occurrences of NEU2. Another hypothesis might be in relation to the types of trauma discussed. In session 1, the client discussed a singular traumatic event she

experienced as a child, her rape by her uncle in 3rd grade. The client-participant in this study was that of a resilient young woman who reportedly set boundaries as a child, which per report, ultimately contributed to the sexual abuse stopping. Additionally, the therapy session occurred in a board-game format, discussing certain topics after rolling the dice and taking turns. Therefore, the discussion of her trauma consists of the fewest talk turns, for at least two reasons. First, given her resilient presentation, she may have pulled for fewer simple reflections from the therapist, though there is no research to support such a hypothesis. Second, the trauma discussion might include the fewest talk turns given it was only discussed by chance, when the dice were rolled and the topic cards were chosen randomly.

On the other hand, these differences might be accounted for by therapist-characteristics as well, such as therapist's style, culture and theoretical orientation, therapist's utilization of facilitative statements versus reflections to show she was listening, or the therapist's own avoidance of verbally summarizing the trauma discussion, all of which tend to affect the therapist/client interactions; however because this study did not look at therapist characteristics, there is no evidence that this hypothesis is accurate for the current study.

In session 2, a less stigmatizing form of trauma was discussed, medically related trauma, which might have also pulled for less verbal confirmation of the client being understood. Literature suggests that the type of trauma experienced can create barriers to disclosing based on levels of social-acceptability of the traumatic event itself (Kogan, 2004; Sorsoli, 2009; Ullman 2007), which offers the question of whether this

phenomenon also applies to the listener of such an event. In such a case, the therapist may be more hesitant to respond with verbal confirmation of the discussion/disclosure.

Additionally, the therapist in session 2 tended to have an agenda she pushed throughout the session; therefore, the therapist might have been more leading, and thus categorized as having negative responses versus listening/reflective. As the clients and therapists were not interviewed, and there is little information in the literature regarding how therapists respond to types of trauma, these hypotheses cannot be confirmed.

The following excerpt from session 2 exemplifies the therapist's leading style , T45:

“(interrupts client), So you were sitting and thinking about the things that were upsetting you while you were having your tea?” After the client denied in C46, the clinician suggested in T46 that when the client is feeling upset, maybe she could write things down to get her hands moving, instead of scratching. In C47 the client reminded the clinician about how this exercise would be difficult for her given her disability and being unable to see, and asked if she should be able to read what she is writing. The therapist responded in T53, “No.. I think just getting it out.. we can see if it works, cause you said you had several frustrating experiences during the day? And so maybe the feelings came up subconsciously?” She continued to push this idea, though the client has denied feeling upset, and discusses subconscious versus conscious thought and how the client might be feeling distress even when she doesn't consciously realize it. She then suggested the client do the exercise, when she's not realizing consciously that she's upset but instead when she begins to scratch. She finished with, “It's just a thought...” C63: “No, I, I think..” T63: “(interrupts client) We can see how it works (smiles).” As is seen in this example, the therapist pushed her own ideas rather than listening and reflecting what the

client reported to be feeling/not feeling. This pushing occurred again in T126 when the clinician suggested that the client had experienced a lot of loss lately. The client disagreed in C126, and the clinician again interrupted her by saying “but even the thought of losing a toe, that’s a loss” (T127), needing to be heard, rather than waiting for reflective opportunities by listening for what the client was feeling/thinking.

Results Patterns Related to Positive Responding

Results from the present study assert that positive responses were the second most frequent overall category across all five fully coded sessions and talk turns, comprising 21.71% of all codes (15.55% of TDS; 0.523% of NTD). Having high rates of positive responding throughout sessions is important when comparing findings to past research. For example, traditional theories and research on trauma may focus on negative aspects of coping with trauma, and underestimate both an individual’s ability to stay stable and healthy in the face of a trauma and grow from the experience after the trauma (Linley & Joseph). For therapists, adopting a positive psychology/strengths-based perspective, perceiving clients as survivors versus victims, and supporting clients as they re-harness their power and strengths after a traumatic event, can lead to posttraumatic growth and the reduction of negative symptoms in trauma survivors (Avey et al., 2011; Briere & Scott, 2012; Josephson & Fong-Beyette, 1987; Lee et al., 1976; Palmer et al., 2001).

Taking positive responses into account, the present study categorized positive responses into one of the following three categories, Validating Responses (POS1), Supportive Responses (POS2) or Empathic Responses (POS3), which resulted in a total of 109 codes within the trauma discussion sections, or 15.55% of TDS. The distribution within the positive code category resulted in Validating codes (POS1) comprising

62.39% of the positive responses; Supportive codes (POS2) comprising 31.19% of the positive codes; and Empathic codes (POS3) comprising 6.42% of positive codes. Some patterns found when comparing positive responses to one another, as well as when comparing the positive category to other categories, are discussed below.

Frequency patterns across positive responses. When examining POS1 data, this study found that this category of responses had the second most frequent presence when compared to all codes, across all five sessions within the TDS ($n = 68$), but as described above, had the third most frequent presence in the NTD ($n = 20$). As defined in the coding manual, Validating (POS1) responses included responses that conveyed acceptance or understanding of the client's thoughts feelings and behaviors related to the traumatic event, and as previously discussed, sometimes this can take the form of utilizing a complex reflection to reflect inferred meaning of a statement or to reflect the client's underlying feeling.

Of note, POS1 was not only the second most frequently occurring code across all codes in the TDS, but also occurred 1.66 times more often than both the POS2 ($n = 34$) and POS3 ($n = 7$) categories combined. Supportive Responses (POS2) were defined to include encouraging responses of the therapist-participant and/or those that advocate for and empower the client, and empathic responses (POS3) were defined to include statements in which the therapist-participant included "I statements" to convey that she was able to imagine that she was the other person, who experienced the situation.

It also should be noted that there were no instances of empathic responding (POS3) in either session 1 or session 3. In fact, empathic responses (POS3) represented the least frequently coded response across all code categories, all individual codes, and

all sessions. The results from the present study yielded only nine total instances of empathic responding, across all five sessions talk turns (0.66%), seven of which occurred within the trauma discussion sections of those same five transcripts (1.00%). That means that empathic responses accounted for only 1.49% of all TDS codes.

While there is no literature that states one type of positive category to be more effective or more helpful than others, a study by Palmer et al. (2001) interviewed clients who had sought professional mental health treatment to discuss traumatic experiences. What they found was that the highest number of clients cited listening/being empathic as how services were the most helpful ($n = 35$); feeling empowered was cited by 26 participants; and validating the survivor's experience was cited by 14. Given the distribution, it might be speculated that clients may perceive POS3 or empathic codes as most helpful, POS2 or supportive codes second most helpful, and POS1 or validating codes third most helpful, the opposite pattern of what was found in this study. Future research is needed to test out such hypotheses, as the current dataset precluded interviews with study client-participants.

This researcher did not expect to find such low frequency of POS3 codes for other reasons as well. First, because empathic responding is consistent with the basic skills needed for helping professions (Josephson & Fong-Beyette, 1987; Jourard, 1964; Palmer, 2001), she made the assumption that this type of responding would have happened frequently. Not only is empathy “an essential ingredient of therapeutic practice, and a key concept in attempts to understand how therapy works” (Bohart & Greenberg, 1997, p. 4), clients have named empathy as being a very important tool in therapy during the discussion of trauma (Josephson & Fong-Beyette, 1987).

Additionally, as the MI literature references, the use of reflections, both complex and simple, both of which occurred extremely frequently throughout the sessions, tend to help set up the counselor to better express empathy, given the reflections are used to convey understanding of the client's experience (Miller & Rollnick, 2012). Given there was a plethora of reflections in the form of both POS1 (the second most frequent code) and NEU2 (the third most frequent code), one might hypothesize that frequencies of empathy would follow suit.

While this finding seemed salient, it is unable to be studied directly given the lack of knowledge about each therapist, the therapist-client relationships, body language and other behavioral observations, and how each client experienced the therapists in sessions (e.g., empathic versus unempathetic), leaving only the proposal of questions and hypotheses. Some hypotheses regarding explanations of the low frequency of empathic responses might include the fact that the therapists in the present study were perhaps truly less empathic than other therapists or that therapists in general might consider themselves more empathic than they actually are in session. While there is some extant literature regarding empathic accuracy, or one's ability to empathically infer what another is thinking in an accurate way (Ickes, 1997), there is little research regarding comparisons of presumed versus actual rates of empathy in session by therapists.

Other hypotheses might include the idea that empathy was actually occurring in the session; however, this study was unable to measure it given the focus on strictly verbal responses. Existing literature draws on the model that therapists can express empathy and other positive factors both verbally and nonverbally, and that clients tend to feel most secure when the therapist expresses these things via both means (Lee et al.,

1976). Such effective non-verbal expressions tend to include eye contact, body trunk lean, concerned expressions, and physical closeness to the client (Lee et al., 1976), none of which were able to be studied in the current project.

Finally, the definition of empathy via this research study, may have also contributed to the low frequencies of it across sessions. This study utilized a somewhat narrow definition (only using therapist “I” statements intended to convey understanding of the client’s experience), in order to differentiate validation, support, and empathy, and to promote clear guidelines for coders and increase interrater reliability. By having such a clear definition of empathy, instances of empathy without a therapist “I” statement might have been left out.

Within session findings. When comparing individual session TDSs to one another, the present study found variability related to positive responses. Namely, out of all five TDSs, session 3 had the most positive occurrences ($n = 34$), while session 1 had the fewest ($n = 5$). Sessions 4, 2, and 5 decreased in frequency of positive responses as well, (session 4, $n = 32$; session 2, $n = 22$; and session 5, $n = 16$). A different pattern was present for NTD results, (session 5, $n = 11$; session 1, $n = 10$; session 4, $n = 7$; session 3, $n = 5$; session 2, $n = 2$).

One way to examine such differences within the TDS is to relate them to trauma type because research posits that it can be more important to respond positively for those clients with longer trauma, increased betrayal traumas, and more severe traumas (Briere & Scott, 2013; Herman, 2009; Hong et al., 2011; Kessler & Goff, 2006). If the current study applied the current research to the finding by looking at the distribution as compared to types of trauma, session 3 had the most diversity across reported traumatic

events, as in the client-participant experienced physical trauma, emotional trauma, and sexual abuse for long periods of time during childhood, and also had the highest number of positive responses, which according to the literature, is ideal, However, the second most intensive trauma experienced was that reported by the client-participant in session 5, where the client-participant experienced extensive childhood sexual abuse from two perpetrators, and maternal neglect. Despite this, session 5 had the second to least amount of positive responses, therefore not fitting with the current literature's suggestions.

Session four also included disclosures of childhood sexual abuse by the client-participant as well as a current triggering event of the client-participant's daughter possibly experiencing CSA as well, and did contain the second highest amount of positive responses. The client-participant in the second session discussed an extensive medical trauma history and the client-participant in the first session disclosed a singular event of childhood rape, and both had lower instances of positive responses, also in accordance with the literature, explained in more detail below.

Given this data, it seems as though the current pattern as far as severity, level of betrayal, and chronic traumas would be 3, 5, 4, 2, and 1 from most to least. While this distribution doesn't exactly fit in relation to frequency of positive responses by therapists in session (as this pattern contains sessions 3, 4, 2, 5, and 1 from highest amount of positive responses by therapist, to least), the theory would still fit for sessions 3 (most positive responses and most severe, chronic, betrayal trauma), and session 1 (least positive responses and least chronic trauma in comparison to all 5 sessions).

Results Patterns Related to Negative Responding

Results from the present study assert that negative responses, overall, were the least prevalent codes. When looking across all five fully coded sessions and talk turns, negative responses comprised of 15.23% of all codes (11.27% of TDS talk turns; 3.29% of NTDS talk turns). With positive responses at 21.71% of all codes, there is only a 6.16 point difference between percentages of negative and positive responses across sessions. In the present study, coded responses that were considered negative were categorized into one of the following three categories; Invalidating Responses (NEG1), Unsupportive Responses (NEG2), or Unempathetic Responses (NEG3). Some patterns found when comparing responses to one another, as well as when comparing the negative category to other categories are discussed below.

Frequency patterns across negative responses. The presence of negative responses across the sessions was not surprising, as the research indicates that a trauma survivor may be met with a negative response (Gable et al., 2006). Although the fact that negative responses to trauma disclosure/discussion had the fewest codes is promising, results still are concerning given that a negative response to the disclosure or discussion of trauma can be damaging for the survivor and can result in harming effects as well as diagnostic implications (Rieck et al., 2005; Shenk & Fruzzetti, 2011).

Despite the extant research linking negative responses to the discussion of trauma to negative effects for the clients, client resiliency should not be forgotten as extant research also notes that survivors of trauma tend to be resilient and may experience significant symptoms reduction over time, probably as a function of the self healing process. In these cases, invalidating disclosures might not have such an impact on clients

who are experiencing such resiliency, and clients might experience lower levels of problematic outcome in regards to potentially invalidating responses (Briere & Scott, 2012). Again, without having collected the data on these types of variables, it is impossible to make a clear assertion either way.

Similarly, given the limitations of the study, in which the researchers were unable to ask the clients directly about how the therapist came across to them, and given how client perceptions of therapist responses might be different than therapist perceptions of the same responses, it is unclear as to whether any of the clients perceived their therapists as having negatively responded in the first place.

That being considered, the most frequently coded negative response was that of the unempathetic category (NEG3, 49.37% of TDS; $n = 39$), which appeared as the fourth most common code across neutral, positive, and negative codes, and was more frequent than even supportive (POS2, $n = 36$) and empathic (POS3, $n = 7$) categories of the positive type. Invalidating (NEG1, 40.50% of TDS; $n = 32$) and Unsupportive (NEG2, 10.13% of TDS; $n = 8$) responses were also each more frequent than POS3 codes.

Regarding unempathetic responses (NEG3) in particular, instances of the therapist-participants being demanding of or pushing expectations on the survivor were the only subtype of NEG3 responses, the distracted subtype from the coding manual was not seen across the 5 sessions. The lack of this subtype might also be due to the lack of ability to measure behavioral cues/responses in this particular study. Katz (1963) noted that unempathetic responses are somewhat common during discussions of traumatic material, and that while therapists may mean to respond empathically, they may be unable to do so given the difficult content of the discussion. Consistent with this

literature, in the present study, the clinicians appeared to be attempting to offer support; however were doing so in a way that was pushing their own ideas or agendas. For example, as previously noted, in transcript 2 the therapist pushed the client to write down her feelings (even though she was unable to see or read at the time given her medical trauma).

Current research suggests that clients should be offered and given options about support and support types, but should not be forced or coerced into completing a certain treatment or exercise (Read et al., 2007). Ideally, the client and clinician should work collaboratively to come up with something the client might find helpful, and otherwise empower the client in the process (Read et al., 2007). Similarly, in session 5, the clinician inquired about the sexual abuse and the client's dissociation and the client responded, "Yea, it. It wasn't me and I don't want to go there because I don't know if I can" (C262), to which the therapist replied, "You don't want to go to the actual experience?" (T262), which was pushing expectations on the client as the client stated she was afraid she couldn't go there, whereas the clinician accused the client of not wanting to go there. The clinician might have utilized the client's disclosure of being afraid to discuss it by collaboratively attending to ways in which the client might feel comfortable and supported.

Invalidating responses (NEG1) included instances in which the therapist-participant met the disclosure with an inappropriate, punishing, trivializing, or judgmental response, or was dismissive of the discussion/disclosure. Originally, as noted in the methods section, NEG1 included the "neutral/no-response" categories, until the full neutral category was created during the preliminary coding process. This subdescription

was removed and the above noted subdescriptions of NEG1 remained. The majority of the responses tended to be of the last descriptive category, the listener being dismissive of the discussion/disclosure. From the current literature, it is known that for some clinicians, not being sure how to respond to a client's discussion of trauma may be a reason for not asking about it in the first place (Young, Read, & Barker-Collo, 2001). Therefore, as this study suggests, some therapists might simply not know how to respond, and dismiss the topic or parts of it that are uncomfortable for them.

In session 2, a possible example of the therapist-participant being dismissive of a topic that may have been uncomfortable for her occurred in the following example, as the client attempted to describe the nature of her eye surgery and her feelings about it; yet, the clinician continued to ask clarifying questions in a distracting way. For example as the client attempted to describe the surgery and her fears, the therapist asked this series of questions:

T75, "and then when will you know if it was successful or not?", T78, "So you will have clearer vision?," T82: "What about pain? Do they expect that you will have any pain?," T86, "Who is taking you to the operation?," and T87, "So you will have two friends?"

While this series of interactions was coded in the neutral direction, it might seem as though a client who was attempting to discuss her feelings and fears about the upcoming surgery might interpret this as a negative, dismissive reaction. Given that the client is attempting to discuss these things, it seems as though the therapist, by averting the specifics of the topic by using clarifying questions, might be the one who is uncomfortable with the topic. However, each of these are assumptions and hypotheses,

given the fact that this study did not interview the client directly to get her perspective on how she interpreted the therapist's responses.

Additionally, research asserts that therapists may be afraid of vicarious traumatization when hearing details about a traumatic event, or may anticipate that the client may have an emotional reaction that is too intense for them to handle (Bicknell-Hentges & Lynch, 2009; Josephson & Fong-Beyette, 1987; Martsof et al., 2010; Read et al., 2007). These reasons may have affected the therapist-participants in the study to have their responses coded as dismissive of the topics or discussions.

Unsupportive responses (NEG2) included responses in which the listener exhibited disbelief, belittled the client, or reacted with outrage or horror at the survivor, offender or non-protective social supports of survivor. Unsupportive responses only occurred 8 times across all sessions, which is promising given the literature regarding such responses. Research asserts that damaging effects from negative responses may be more likely to occur with certain reactions, such as those in which the respondent reacts with shock, horror, distress, blame, or disbelief (Butler, 1978; Courtois & Watts, 1982; Josephson & Fong-Beyette, 1987), some of which are represented in the NEG2 category. Examples of the therapist-participants belittling the clients occurred in session 2 T129, such as, "Where is that coming from? Because clearly you needed to be in the hospital."

Action versus listening responses. As previously noted in the positive section of the discussion above, transcripts 1 and 2 had higher rates of negative responses than positive responses. Despite the trainee therapist-participants likely having good intentions for supporting and validating the clients in these two sessions, negative responses prevailed over positive (validating, supportive, empathic) responses.

In session 2, the client discussed engaging in self-harm scratching behaviors, and the clinician continuously asserted both what the cause might be, though the client did not agree, and how to *fix* this or stop doing it. In the process of suggesting how to fix the scratching, the therapist continuously asserted that the client, who had medical trauma related to her eyes, going blind, and a number of surgeries, should write down her feelings. The client discussed how in her current state this might be difficult, yet the clinician continued to push. A related hypothesis for why this phenomenon might occur relates to the finding that therapists might have the urge to want to *do something* or implement a premature intervention immediately when the trauma is discussed (Read et al., 2007).

The idea of wanting to take action or “fix” the problem can sometimes result in a mismatch of goals, the therapist pushing expectations that the client might not be ready for, or the therapist being dismissive of important information in order to keep on the path of *fixing* with interventions or suggestions that they imagine to be most helpful to the client (Bicknell-Hentges & Lynch, 2009; Read et al., 2007). Zoellner et al. (2011) found this point especially true for novice clinicians who might be trying to provide structured, manualized, and/or goal-directed treatment, that was recently learned, or promoted with supervised guidance, or an area of interest/research expertise for the trainee.

In the midst of being so goal-directed and structured, therapists might lose focus on basic therapeutic skills such as engaging in listening behaviors, which is the opposite of the urge to try to take action or fix the situation (Zoellner et al., 2011). The literature highlights the importance of being a non judgmental listener, and creating a safe place for

the client to share traumatic material; but by focusing too heavily on obtaining information, or trying to fix a problem, the therapist might create an environment lacking in common therapeutic characteristics that allow for such important things (Zoellner et al., 2011). By simply listening, the therapist also promotes a strong therapeutic alliance, and allows the client more space to discuss feelings and affective content, which as discussed in the neutral discussion section, is extremely important when healing from trauma. Without doing so, the therapist might unwittingly discourage a client from exploring and approaching issues that are already feared and avoided by their nature (Zoellner et al., 2011).

Within session findings. Another noteworthy finding was that sessions 1 and 2 had higher instances of negative responses than positive responses (session 1: pos, $n = 5 < \text{neg}, n = 10$; session 2: pos, $n = 22 < \text{neg}, n = 29$). Therefore, the overall patterns of responding found in sessions 1 and 2 included neutral, negative, positive (from most to least). In each of the 3 other sessions, negative responses had the least numbers in regards to frequency. This pattern of having higher levels of negative responding is reminiscent of results from three other behavioral studies conducted in both New Zealand and USA (Agar & Read, 2002; Eilenberg et al., 1996; Read & Fraser, 1998) that reported very low levels of positive response by mental health professionals (i.e., nurses and psychiatrists) in terms of types of responses such as offering support, providing information, referring clients for counseling, documenting the abuse in the patients' files, asking about previous disclosure or treatment, adding the summary to treatment plans, and considering reporting to legal or protection authorities.

Since research posits that it is important to respond in a positive way when responding to trauma, it is unclear how responding in a “mostly” positive way, or “mostly” negative or neutral way might affect a client. Given we were unable to speak directly to each of the client-participants about the overall feel of the sessions (e.g., did they feel the therapist responded to them positively, negatively, or neutrally?), and due to the fact that trauma survivors perceptions may be different from the therapist’s perceptions of type of response, this is unable to be confirmed.

Client reactions to negative responses. While the current study was unable to directly study client reactions to negative responses, existing literature discusses such topics. The research suggests that negative responses might lead to feelings of betrayal, stigmatization, and powerlessness, which can ultimately damage the therapeutic alliance (Martsolf et al., 2010; Weaver et al., 1994). Additionally, research highlights that clients who perceived therapists and professionals as having a negative reaction reported a lack of trust in them and stopped therapy or treatment after disclosure (Josephson & Fong-Beyette, 1987).

Given both the limitations of the study, in which the researchers were unable to ask the clients directly about how the therapist came across to them, and how client perceptions of therapist responses might be different than therapist perceptions of the same responses, it is unclear as to whether any of the clients perceived their therapists as having negatively responded. Additionally, as each of the five sessions included neutral, negative, and positive responses in different percentages, and there is no current literature to reference regarding how the overall session was affected by these different percentages, it is unclear as to how each client-participant would categorized the

session/listener. Work by Shenk and Fruzzetti (2011) asserts that neutral responses can be just as harmful and damaging as negative responses; therefore, it may be possible that each of the clients in the five transcripts found their therapists to be more negative than positive.

Patterns Related to Adjunctive Responses

While reviewing positive, negative and neutral responses in the current study, a process developed through coding in which adjunctive coding categories were created. In other words, codes were created both as an addition to existing main codes, and as stand-alone codes in cases where there was no main base code. The categories created included one for missed opportunities by clinicians (for positive responses), and one for clinical terminology used by clinicians. The basis for these codes related to extant literature supporting the use of positive codes (versus negative or neutral codes), as well as a strong therapeutic alliance, psychoeducation, and collaborative treatment as a best practice for trauma survivors (Briere & Scott, 2012; Martsof et al., 2010; Olio & Cornell, 1993; Shenk & Fruzzetti, 2011; Zoellner et al., 2011).

Missed opportunities (+) or any clear opportunity in the transcript in which the therapist could have used a positive response, were coded via a plus sign (+). Across trauma discussion sections, Missed opportunities (+) were found to be the fourth most coded overall TDS response ($n = 50$) comprising 10.66% of TDS codes and tied for fifth most coded NTDS response ($n = 13$). Within the TDS, this code represented 50 opportunities across sessions in which the coders determined that clinicians could have utilized validation, supportive responses, and/or empathic statements during trauma discussions. As is known from the literature, responding in a positive manner can lead to

more positive growth opportunities for clients, faster healing, and stronger, safer therapeutic relationships, whereas responding in a negative or even neutral way, may lead to more severe consequences and diagnostic implications for clients (Bonnano, 2008; Courtois, 2008; Linehan, 1993; Pruitt & Zoellner, 2008; Shenk & Fruzzetti, 2011).

In relation to individual sessions, session 2 had the highest number of missed opportunities ($n = 16$). Sessions 4 and 5 also had similar numbers of missed opportunities at 14 and 12 respectively. Sessions 3 and 1 however, had few missed opportunity codes, with session 3 having only 5, and session 1 having only 3. While there is no extant literature regarding frequencies of, or patterns of missed opportunities, there is research to suggest that therapists who miss “now moments” (Stern, 2004, p 176) in which they could have responded to clients in a way to promote change, can actually result in missed opportunities for change, with negative therapeutic consequences. Additionally, existing literature uses the term “missed opportunity,” in other contexts, such as when discussing the failure to discuss important topics, such as the client getting them a gift, or failing to ask about substance use (Freimuth, 2010; Zur, 2011). In contrast, the current study utilized this measurement as a way to note the magnitude of opportunities that trainee-therapists have to utilize basic therapeutic skills (such as empathy, validation, and support) when responding to trauma disclosures.

Clinical discussion (*) or instances in which the therapist-participant used clinical terminology or psychoeducation when speaking to the client about the traumatic event or presentation (e.g., recovery, symptom presentation or treatment) were coded with an asterik (*). Across trauma discussion sections, Clinical codes (*) were found to be the

eighth (out of ten) most coded overall TDS response ($n = 20$) comprising 4.26% of TDS codes, and across the NTDS ($n = 7$), was the 6th of 8 most coded overall response.

In relation to individual sessions, session 4 had the highest number of clinical language ($n = 9$). Sessions 1 and 2 also had similar numbers of clinical language at 5 and 4 respectively. Sessions 3 and 5 however, each only had 1 instance of clinical terminology in the TDS. While there is no extant literature regarding frequencies of, or patterns of such language in trauma sessions, the current study utilized this measurement as a way to note instances in which trainee therapists utilized clinical terminology to assess, gather information, or explain when responding to trauma disclosures.

Psychoeducation versus therapist opinions. During coding, psychoeducation was distinguished from the phenomenon of clinicians giving their opinions or advice to clients. Psychoeducation could be considered a positive part of trauma treatment because educating clients about the process and symptoms of PTSD reactions, posttraumatic growth and resilience, and the process and efficacy of therapies to treat PTSD is said to be important for clients to feel a sense of empowerment and control in the therapeutic process (Schacter, Radomsky, Stalker, & Teram, 2004). There were 20 statements that occurred across overall sessions, all of which fell within the TDS, which included clinical discussion of some kind, and were considered psychoeducation.

Similarly, there were 17 instances of therapists giving advice or their opinions across each of the five sessions, except for session 1. For example, in session 5, after the therapist suggested that the client might be feeling anxiety, to which the client questioned the therapist about what she was feeling was actually anxiety, the therapist replied, “that’s usually what the feeling is.” In transcript 4, another example included, “Kids are

funny, they're resilient as hell. It's not until something comes up that you can tell that you were the caretaker for yourself when you were a kid." Since the therapist-participant stated these opinions in such a confident manner, it might be understandable if a client-participant had difficulty deciphering whether what the clinician said was clinical fact, or opinion. It is worth noting that among the extant research, advice giving and opinion giving are advised against in trauma treatment, as it is noted as a form of controlling treatment (Adshead, 2000).

Other Therapist Response Patterns Found

While not studied directly via the coding process, the researchers went back after coding and counted globally the frequency of other types of responses found during the process. First, facilitative statements (e.g., "right," "okay," "mhmm," "hmm," "yes") across all five transcripts were counted to total 679 responses (49.56% of all therapist responses). As is known from the literature, use of these facilitative statements is common in everyday language, and typically accounts for 19-35% of therapist utterances (Ferrara, 1994). When comparing the current results to these numbers, the result from the current study was higher. As this number only represents the total number of facilitative statements across all talk turns and does not distinguish between trauma discussion and non trauma discussion talk turns, the higher percentage cannot be definitively explained by the sessions being trauma focused sessions. The use of such statements is known to be helpful when regulating the flow of talk and keeping the expected asymmetry that exists in therapeutic relationships (Ferrara, 1994); however, when used during the client's discussion of trauma, it can be questioned whether there is a better use of language that has a more positive contribution.

Additionally in the trauma research, discussions regarding the need to say something versus the need for just listening highlight another possible use for facilitative statements in trauma discussion (Palmer et al., 2001). Facilitatives serve the purpose of listening while acknowledging that the listener is doing so. However, this cannot be confirmed without the behavioral observations, which research posits to be of utmost importance in the delivery of such statements (Lee et al., 1976). The limitations of the current study prohibited the researchers from measuring tone of voice, body language, facial expression, and intonation, and coding these responses as positive, negative, or neutral. As body language, and discussion flow both have a large impact on how these statements might be received by the client, and there was no way to measure how the client perceived such responses, a decision was made to leave them out of the coding process.

Similarly, compliments, which occurred a total of 49 times across all sessions and all talk turns, were also excluded from the coding process. During coding, researchers discussed whether compliments should be their own category, or a part of the supportive category. It was decided that compliments should be left out because trauma survivors may receive them either as invalidating, if, for example, the compliment does not resonate with them (Gable et al., 2006), or as positive, if they feel flattered or empowered by such a comment. Given that we were unable to study how the client-participants received such responses, the compliments were totaled rather than coded.

Lastly, interrupting was also observed throughout the sessions, mainly in sessions 2, 3, and 4. Again, this type of responding was left out of the coding process due to the complex nature of how it might have been received by clients, and was observed. Four

kinds of interruptions were noted. First, therapist-participants interrupted clients' flow of speech to ask a clarifying question. The therapist might have done this in order to change the topic of conversation away from trauma discussion, as many of the clarifying questions were not necessarily integral in understanding the traumatic experience of the client. The literature suggests that the process of discussing trauma might manifest in a similar fashion, with discussions approaching traumatic material in the discussion and then withdrawing from that discussion temporarily (Alaggia, 2005; Chaudoir & Fisher, 2010; Lindbald, 2007).

Second, during intake procedures, interrupting appeared to be used somewhat strategically in order to get through the amount of information needed for an intake session. Research supports the use of interruptions in this way, specifically when using structured or active/focused therapies such as CBT (Beck & Beck, 2011). Particularly in an intake session during which the therapist is responsible for gathering large amounts of information, this type of technique might have been warranted. In the current study, the clinician introduced this idea to the client in T6, stating, "and because this is an intake, it's gonna be more of a question and answer period so I can get familiar with you." Additionally, there were 28 instances in the intake session in which the therapist-participant gently interrupted the client to continue to gather information.

Third, interruptions were used when clinicians were pushing agendas and/or suggestions on the clients, typically when clients did not agree with the suggestions being pushed. Lastly, interruptions in the form of clinicians interrupting to finish the clients' sentences for them occurred across sessions. In the last two examples of types of interrupting the way they are received by the client also depend on the therapeutic

relationship, cultural and personal backgrounds of both the therapist and clients, and the tone, body language, and facial expressions of the therapists as they are occurring.

Hypotheses Related to Trauma Discussion

As noted in the literature review, the decision making process that each client goes through in relation to actually discussing or disclosing their trauma can be as complex as the decision the therapist goes through in relation to how to respond to such disclosures/discussions. When looking at the present study, it can be assumed that each client-participant in transcripts 1-5 had to go through a similar decision making process about when, where, and to whom to disclose their information. As noted above (and noted below in the limitations section), for the present study, we lacked additional information about each client-participant's individual process, such as who else she disclosed to in her life, whether or not she had disclosed this before with the therapist, or to others in general. Given the difficulties that survivors can face in deciding whether to, and/or when to disclose, many survivors of trauma seek professional help to deal with their experiences (Palmer et al., 2001), as in the case of the client-participants in the present study.

When examining the discussions in the current study, slightly over half of all talk turns were considered to be trauma discussion (701 talk turns), while the remaining 48.83% were considered to fall outside of the trauma discussion bounds (669 talk turns). It should be noted however, that the sessions were specifically chosen due to the fact that it had at least some trauma discussion content. The breakdown across each individual session consisted of the following percentages of trauma discussion, from highest to lowest; Session 2 had the most discussion of trauma in the session (84.13% of talk turns

contained TD); Session 3's discussion of trauma made up 64.03% of the session; Session 4's trauma discussion totaled 61.41% of the session; 47.18% of Session 5 was considered trauma discussion; and 26.08% of Session 1 comprised trauma discussion.

Across the trauma literature, the discussion of trauma is noted as both difficult and therapeutic (Deblinger, et al., 2011). One of the factors that influence the survivor's experience is the response by the listener (Deblinger et al., 2011). For a multitude of reasons, most of which include fears surrounding how the listener might react (e.g., anticipated negative responses), it is common for survivors to be hesitant to disclose traumatic events to others, and to delay or not disclose (Deblinger et al., 2011; Derlega et al., 2004; Goodman-Brown et al., 2003; Ming-Foyes et al., 2009; Read et al., 2007; Rieck et al, 2005; Segal et al., 2008; Sorsoli, 2010). For example, a US study found the average time before any disclosure by individuals who had suffered childhood sexual abuse was 9.5 years (Frenken & Van Stolk, 1990). The extant literature describes the process of disclosing traumatic material to another as one that is truly complex, in which the survivor might consider things such as the timing of the disclosure, listener's perceived mood, how others have reacted in the past, and whether the listener has asked directly about traumatic events (Chaudoir & Fisher, 2010; Kogan, 2004; Ullman, 2007). Given that these variables were unable to be studied in the current research due to lack of information, these aspects will be discussed in limitations to the study.

While there is no extant research that looks at time of discussion of trauma in an actual session, there is research that supports the notion of hesitation to discussion trauma based on how stigmatizing the traumatic event might have been. Such research about disclosure suggests that many survivors may be hesitant to disclose trauma and that there

are higher rates of difficulty with disclosing for survivors of stigmatizing traumas (e.g., child sexual abuse, rape etc.; Kogan, 2004; Ming-Foyes et al., 2009; Sorsoli, 2009; Ullman, 2007), the results of this study in relation to analysis of trauma discussion within sessions, seem to support this notion, though it should be noted that in the context of this study, it is unknown if this was the first disclosure, or whether the distribution of TD is typical in relation to other sessions the client and therapist had during their treatment.

Findings that support the idea that there are higher rates of difficulty in disclosing trauma based on the stigmatizing nature of the trauma from this study included the following. First, the type of trauma disclosed in Session 2, in which trauma was discussed for the largest percentage of time (84.13%), was trauma related to a medical condition while the remaining transcribed psychotherapy sessions (that had less discussion volume per session), included types of more stigmatizing traumas, and all included disclosures of childhood sexual abuse or sexual assault (thought of as the most stigmatizing form of trauma; Ming-Foyes et al., 2009) in some capacity. Session 3 with the second highest volume of trauma discussion per session (64.03%), included physical and emotional traumas as the main discussion points, which again, tend to be less stigmatizing than sexual abuse. References were made by the therapist-participant in session 3 about client's history of sexual assault as well, though the majority of the discussion was in relation to emotional/physical forms of abuse.

The remaining three sessions included discussions of childhood sexual abuse in differing forms of severity. Session 4 (64.41% TD) focused mainly on the client-participant's concerns regarding her daughter having been sexually abused, which triggered her history of abuse. While there are many other reasons that may explain or

contribute to the lack of time spent on discussing the trauma, one reason for the high rate of discussion could be that this client-participant was speaking mostly about her daughter's potential situation versus discussing her own trauma specifically. In Session 5, which discussed trauma 47.18% of the time, extensive discussions regarding her mother's neglect as a form of trauma (which was less stigmatizing than her history of CSA) occurred, and as prompted by the therapist, discussions of client's chronic childhood sexual abuse that occurred for many years by both a neighbor, and her father, took place as well. Given the extensive abuse the client-participant experienced and the stigmatizing nature of part of the abuse (CSA versus neglect) it is not surprising that she had the second to least volume in regards to discussion and that more of the trauma discussion was focused on the neglect versus the childhood sexual abuse. Lastly, the client-participant in Session 1 spoke about trauma the least (26.08% of the session). This client experienced rape by her uncle in 3rd grade, though it did not go on chronically. Given both the solitary nature of the client's trauma (one instance of rape versus chronic CSA), and the stigmatizing nature of this client's experience, it could be noted that there might be a relation between those variables and the low frequency of trauma discussion, when compared to the other transcripts.

While some connections can be seen between types of abuse and difficulty with disclosure, there are likely other factors that come into play with clients' decisions to disclosure. As noted above, disclosure can be a difficult and trying process, that entails a long process of decision making for each individual client. Such variables were not able to be studied in the current research context given the inability to gather information such as timing of the disclosure listener's perceived mood, how others have reacted in the past,

and whether the listener has asked directly about traumatic events (Chaudoir & Fisher, 2010; Kogan 2004; Ullman, 2007).

Implications for Training

Given the findings discussed above, there are numerous implications for training. The need is high given that many trauma survivors seek professional help to deal with their experiences and the reactions/responses of these helpers can be critical to their recovery (Palmer et al., 2001). As found in the current study and in extant research, therapists will respond in both positive and negative ways to clients who disclose trauma (Josephson & Fong-Beyette, 1987; Palmer et al., 2001). Research has found a lack of generalized training in the area; and for those who do not receive specialized training, a link between perceived lack of training and less comfort in working with trauma survivors (Martsolf et al., 2010).

A benefit of the current study is the focus on how to respond to, not how to treat, trauma discussions in therapy. Given the existing literature supports the idea of the use of common factor approaches similar to the basic therapeutic skills needed from therapists of all trainings and backgrounds (Briere & Scott, 2012; Joseph & Linley, 2008; Kerig et al., 2010; Manarino & Cohen, 200; Moss, 2009; Palmer et al., 2001; Pitchford, 2009; Read et al., 2007), trainee-therapists may already have the skills and knowledge to be able to respond in a positive way to clients who have survived trauma. Evidence from the current study about the relatively more frequent use of neutral and positive responses as compared to negative responses points in this direction. Additionally, the therapists in the current study used validation well. It seemed as though this group was skilled at using reflections, both simple and complex, when listening to trauma discussion/disclosure.

Working in such a manner is likely to improve the therapeutic alliance, which can also increase positive reactions from clients, encourage clients to discuss trauma to others or further at a later date, and promote healing faster (Avey et al, 2011; Briere & Scott, 2012; Palmer et al., 2001).

Yet, the results of this study give support to the need for more education into when, how and why to use common factor approaches such as empathy, listening, being supportive and empowering, and being validating of clients. In particular, current research asserts the importance of empathy while listening to and responding to traumatic disclosures (Bicknell-Hentges & Lynch, 2009; Jourard, 1964; Palmer et al., 2001; Read et al., 2007). Given that therapists from this research study had low frequencies of empathy, though as noted above this could have been the result of multiple factors, improvement can be made in measuring and/or implementing this important technique at the right times.

Other areas for further training involve the use of clarifying questions as means of reducing or increasing intensity around client's affective presentation while discussing trauma as noted in Bicknell-Hentges and Lynch's (2009) work. Using questions in this way might help clinicians conceptualize the use of such questions more thoughtfully, and with more insight into how the questions affect clients. Similarly, a focus on affective versus factual data might be worth practicing during a training program. By addressing this difference in relation to trauma discussion specifically, guidelines based on how helpful such a position is for clients, as well as how to go about doing so in a helpful way could be taught and discussed (Briere & Scott, 2012).

Overall, a training program in which the trainee-therapists' natural strengths are highlighted, while discussing how to apply common factors techniques they may already know to trauma discussion might help to lessen trainee therapist anxiety, reduce avoidant behaviors from both clients and therapists in relation to the discussion of trauma, increase therapeutic alliance ratings, and decrease negative symptoms and trajectories among clients. Such training would not be time consuming. In fact a US study looking at mental health staff who attended just an hour long "trauma orientation" lecture covering prevalence, effects, and sensitive assessment, subsequently identified higher levels of trauma among patients they screened, than those who did not attend the lecture, even though both groups used the same structured interview tool to assess patients (Currier & Briere, 2000). Such a program would also follow APA's 1996 suggestion regarding adding trauma training programs or components to curricula across the United States, and would likely be beneficial to all trainees who are beginning to practice with real clients.

Limitations

The present study included a number of limitations, including limitations typical of a directed content analysis approach. First, the nonrandom purposeful sampling procedure and small sample size of the study limited generalizability of the results. For one, the characteristics of individuals who consented to research may have been those of a special subset of individuals willing to have their data collected for research projects. Another aspect of the small sample size was that the participants only marginally represented culturally diverse populations, even as the researchers obtained cases that appeared culturally and ethnically diverse during the sampling process. Furthermore, a

gender bias appeared within the sample, as each of the therapists and client-participants were females.

Additionally, a limitation of the sample was not having had the ability to gather demographic data about the therapists, given how useful the information might have been when looking at each therapist's responses to traumatic disclosure in order to give context and further meaning to the results found. In relation to types of trauma, while some of the transcripts had clients who experienced multiple types of trauma and overall, types of trauma were represented well (i.e., sexual abuse, physical abuse, emotional abuse, neglect, and medical trauma) the diversity of types of trauma could be improved. For example, most of the client-participants (4/5) had experienced some form of childhood sexual abuse, and no clients had experienced forms of violent trauma such as having been attacked, trauma as a result of war, trauma as a result of a natural disaster etc., therefore limiting the diversity of the sample in that regard. Yet, while the non-random purposeful sampling procedure and small sample size of the present study typically limited the generalizability of findings, the detailed data collection and analysis process, typical of qualitative research in general, created adequate findings for the particular population of interest given the fact that each participant had a uniquely valuable experience or perspective (Creswell, 1998; Merriam, 2002).

Another limitation of using data from an existing archival database was that there was no access to the either client-participants or therapist-participants, in order to gather further information relating to therapist-responses to trauma. Ideally, having an interview with each therapist-participant and client-participant after the study while reviewing a video tape or transcript would have been undeniably helpful in figuring out some of the

why questions related to trainee therapist responses to trauma discussion. Given that the purpose of the study was not to answer *why* questions, but rather to answer *what* questions, the results that were found were able to be compared to extant literature in some ways, in order to hypothesize about some of the more relevant *what* questions related to the results.

Additionally, researcher biases inevitably affected the coding process, such as possibly finding more evidence that is supportive of a theory than unsupportive (Hsieh & Shannon, 2005). The therapists in the current study noticed that they were at times inclined to code negatively versus positively based on previous responses by the therapist-participants; however, with use of the audit trail, journaling, and bracketing, this tendency was attempted to be accounted for and discussed. Another way the researchers attempted to correct for and to prevent against bias was by creating detailed guidelines and operational definitions for each of the codes across all categories. Additionally, coders used in-depth descriptions and rationales for why they coded something a certain way when there were coder disagreements, prior to submitting to the auditor and during the auditing review process. In the same way, contextual factors were overlooked at times despite the decision to include contextual elements of reactions and responses to trauma disclosure during the analysis. Given the audit trail and inter-rater process, these were mostly corrected for, though there may be instances in which errors occurred.

Another limitation was that certain responses did not fit perfectly into certain coded categories, which highlighted some of the limitations of the subjective nature of coding and difficulties with operationalizing complex constructs like validation and empathy, which have perplexed clinicians and researchers for years (Bachelor, 1988;

Duan & Hill, 1996; Kramish, 1954). At times, issues of neutrality, objectivity, and confirmability of trustworthiness posed challenges, but the use of an audit trail was implemented in order to correct for potential biases and to explain each coder's rationale in coding the complex constructs (Hsieh & Shannon, 2005).

Across sessions, the coders were unable to determine the exact timing of the selected therapy sessions as related to the treatment course (e.g., beginning session, 17th/75 sessions, final session) due to database limitations in which therapists did not keep this information in complete form. Had this study been able to access this information, additional context about therapist responses to trauma would have been available. Additionally, the fact that one of the five sessions (Session 4) was an intake session, may have influenced how the therapist interacted with the client, as noted above. Similarly, there was no ability to access information about the disclosure process of each client. It would have been helpful to understand whether this was each client's first time disclosing such a trauma to anyone, whether it was her first or other time disclosing it particularly to her therapist, and how long ago the trauma occurred.

Finally, another major limitation of the study included not having information regarding therapist participant's body language in the form of facial expression, tone of voice, body lean, etc. Given both the subjective nature of viewing and coding body language as well as the difficulties involved in the logistics behind reviewing tapes given location of the tapes, possible poor quality of viewing (e.g., client is far away, at times in black and white, difficulty with making out exact facial expressions etc.), and timing for coders, participant body language was not included. Research notes how important such factors are in creating a safe environment for a client (Lee et al., 1976). Without this

information, this study was unable to include a number of response types as codes since how they were presented by the therapist-participant and received by the client-participant were unable to be identified. Additionally, the lack of this information might have impacted the measure of certain existing codes in the study, such as the positive code of empathic responses (POS3) given that it can be more difficult to perceive a response as empathic without knowledge of what behavioral characteristics accompanied the verbiage.

Contributions

Trauma has been widely researched, and is found in an abundance of clinical situations; however, how trainee therapists respond or react to the discussion of trauma in practice is still in the beginning stages of research. The current study was built on a synthesis of the extant literature regarding responses and reactions to the disclosure or discussion of traumatic events, and used a set of organized codes through which future clinicians might further understand how trainee therapists respond to clients discussing trauma. One major contribution from this study is the coding system, in which four major categories were created (i.e., positive, negative, neutral, adjunctive) and ten response codes were created (POS1; POS2; POS3; NEG1; NEG2; NEG3; NEU1; NEU2, +, *) to classify types of responses by trainee therapists when clients discuss trauma.

Additionally, the present study separated trauma from non trauma discussion to compare results via both means, which no previous research appears to have done.

This study contributed to the emerging literature by examining trainee therapist responses to traumatic discussions in hopes of better understanding how trainee therapists are currently reacting and responding to client expression about trauma, and how the

reactions or responses align with theoretical and research findings. The fact that this research included positive, negative and neutral responses to trauma discussion is novel, as well as its discussion of patterns found across the transcripts, (e.g., the presence of one type of responding over the other) is completely new to the literature on these topics. Results highlighted not only the importance, but the need to increase use of positive responses, and provide education about ways to decrease negative responses. Additionally by tying the positive categories to existing literature about common factors therapeutic techniques, this research highlights the fact that trainee therapists likely have the ability to respond to clients who discuss traumatic events in session in a competent way, but perhaps do not realize either the importance of doing so, or how to apply these factors to trauma discussion.

While the present study did not aim to identify ways to treat trauma, only to respond to them, this too is a unique contribution to the existing literature as there are few publications that speak to how a therapist might respond to trauma discussion. Similarly, this research may potentially help to inform the training of novice therapists in working with trauma, given the existing gap in both the literature and training programs. The results of this study have assisted in learning where the strengths and areas for improvement are among trainee therapists, with the ultimate goal of designing ways to help trainees and their supervisors better serve survivors of trauma.

Directions for Future Research

Given that this study's findings are unlike other research in the area, we hope that this research serves as a starting point for training programs, therapists, and researchers to further examine trainee therapists' responses to trauma in actual psychotherapy sessions.

Continued research in several areas is suggested in order to more fully understand responses to trauma discussion/disclosure in general, what they mean to trainee therapists and clients, and what impact they might have upon trauma trajectories across different cultures, genders, age groups, and types of traumatic experience. In particular, future studies on the impact of therapist responses to trauma discussion should include diverse participants in order to better understand cultural differences and potential variations in the diversity of types of responses, related meanings, and the impact these responses might have.

First, research could continue to focus on understanding and assessing responses to trauma discussion by trainee therapists with a wider sample. The sample might be broadened across different training sites, and/or levels of expertise or training in trauma specifically, in order to differentiate how trauma-training programs affect (or do not affect) therapists' responses to trauma discussion and their effects on survivors.

Additionally, the sample could be expanded to include multiple demographics of both therapists and clients (e.g., gender, race, age) to compare the impact of these factors on therapist-client interactions (e.g., examining the potential impact of client/therapist similarities and/or client/therapist differences) and to examine the transactional and social nature of the responses. The inclusion of more information about therapists might be helpful given that this study provided little information regarding therapist demographics and characteristics. Future research might include a more specific focus on therapist information via demographic surveys, and perhaps gather more information about the types of therapists that are responding to the trauma. Areas of interest might include therapist demographics, therapist training year, specialty training in trauma, and perhaps

even information whether the therapists themselves have experienced trauma or have a trauma history to explore any interactions between how a therapist responds, and her own background/experiences.

Similarly, having information regarding when the selected therapy session took place in the course of therapy (the timing of the selected session in the overall course of therapy) would provide additional information that could shed light on the context and function of the responses (e.g., responding in a positive/neutral/negative way very early in the course of therapy vs. later on). Future studies could then compare the forms and frequencies of types of responses used at different points during the course of therapy, or between therapists and clients of the same or different demographic background as noted above. This addition might help to determine when certain responses are more appropriate given session timing.

Also, by broadening the sample, future research could allow for separation and comparison of type of trauma, length of trauma, and severity of trauma in order to gather more detailed data in relation to responses to such traumas in specific subcategories, which would be helpful given that current research suggests that the consequences of traumatic experiences may vary based on the aforementioned characteristics of the trauma (Briere & Scott, 2012; Herman, 2009; Hong et al., 2011; Kessler & Goff, 2006). Such inquiries could help to further clarify and differentiate whether certain responses are a function of the experience of trauma in general, type of trauma, client characteristics, therapist characteristics, time of session in relation to overall treatment (e.g., intake versus 35th session versus termination), and other factors.

In addition, the forms of future research could be expanded beyond verbal analysis of archival data, as was done in the current study. Future research might also include the use of behavioral observations, which were unable to be included in this study. The use of behavioral observations within and across sessions might give context to facilitative statements, compliments by therapists, advice/opinions of therapists, and interrupting by therapist-participants, thereby adding to the richness and depth of the information and results found. With the potential ability for future researchers to clearly delineate whether a response to trauma was positive, negative, or neutral based on the behavioral response of both the client and therapist, either by way of interview, videotape review, or real-time physiological/bio feedback connections, future clarifications in the coding system (e.g., do positive codes created from the literature actually feel positive to the client) and might bring further insight into the processes at hand.

Another form or direction of future research might be to conduct interviews with clients to gather specific, enhanced information about how they felt when therapists responded a certain way to their trauma disclosure. This could be done either qualitatively or quantitatively. One method might be to observe a naturally progressing session and speak with client afterwards to gather information. Another might be to have participants watch tapes of their sessions and discuss what they were doing or thinking at the time of each response. It might even be helpful to have both therapist-participants and client-participants do so separately in order to get an idea about why the response was given, and how it was received. Another way might be to measure client reactions to therapist responses in different control groups, with therapists responding in pre-set ways, focusing on how certain responses to their trauma disclosure felt. Research in an area like

this might enhance findings of the current study and the coding process used, enabling researchers to potentially test reliability regarding positive responses truly being positive, negative being negative, etc., and would also help to clarify responses that could not be coded based on not knowing how the client might take the response (e.g., clinician laughter after a response occurs, clinician saying, “interesting” after the client shares his or her trauma narrative).

Thus, future studies could further refine and validate the coding system developed to categorize types of responses to trauma disclosure/discussion in the present study. Specifically, the current coding system was based out of the literature, drawing on various studies and empirically-based conceptualizations of responses to trauma discussion, and the effects these responses have on survivors. By examining other data with the current coding system, confirmatory evidence might be provided that the system effectively captures the range of responses typically seen among trainee therapists. If additional potential codes are observed in the process, that were not accounted for by the current coding system, they could be incorporated; conversely, if current elements or codes are rarely observed, the categories could be re-evaluated for efficiency. Lastly, the use of additional coders, specifically of coders who were trained in the coding system, but naive to the study’s objectives would help to strengthen reliability. While the study’s current pre-IR data included averages ranging from 0.94 to 0.526, and the post discussion IR results included perfect inter-rated reliability, there were disagreements on codes and/or confusion about how to code based on the coder’s system during the beginning of the coding process. Once familiar with the coding systems, the coders had higher rates of

interrater reliability across sessions. However, having additional coders might also help to add insight and information into definition creation to refine codes even further.

Other research might include specifically observing the effects of the type of response by the therapist on the therapy/therapeutic relationship itself. Specifically, the relation between therapist responses to trauma discussion in therapy (as observed and coded from videotaped sessions) and the strength of the therapeutic alliance (as reported on self-report measures throughout the course of therapy) could be examined. Perceived progress in therapy (as reported on self-report measures by client-participants at the end of therapy) could also be assessed, to track therapist alliance and how that therapist alliance might be affected by the therapist-participant's response to the client's trauma discussion. Missed sessions after trauma was discussed could be tracked using the therapy log, and/or terminations soon after discussing trauma. By incorporating these measures into a longitudinal design, future research might explore potential risks and benefits of different types of responses directly on the therapeutic process/therapy. Due to the fact that there is both little research in the area specific to how therapist responses to trauma directly impact survivors, and that a large number of clinical populations served by trainee therapists happened to have experienced trauma at some point in their lives, continued research in this area is vital.

In particular, existing research generally examines responses to trauma disclosure outside of the therapeutic relationship, with little attention paid to the direct impact that a therapist's response to trauma might have on the survivor. Accordingly, future research could look at the relationship between responses to trauma discussion (e.g., as measured by the current coding system as applied the discussion of a distressing event) and

psychological symptoms and distress (e.g., self-reported) before the session and directly after the session. If researchers had access to physiological or neurological measurements, this comparison could be done in real time as well. Similar to Bonnano et al.'s (2007) study, long-term outcomes could also be assessed by asking participants to discuss a distressing event, coding for therapist responses to trauma discussion/disclosure, and later (e.g., 5 or 10 years in the future) assessing psychological symptoms and distress, again using a self-report questionnaire. While this might be interesting, there would likely be downsides to other intervening factors that may confound the results over the course of the 5-10 year period, especially given the retraumatization rates among traumatized populations.

Finally, a last thought on possible directions for future research might involve the development of guidelines for therapists regarding how to respond to trauma discussion. More specifically, these guidelines could be developed into a manual, based on the extant literature, to include: an exploration of different ways to respond to clients discussing trauma in session; the risks and benefits of responding to trauma discussion in different ways; and how to help facilitate and maximize therapist responses to produce greater successful therapeutic outcomes for survivors. To test the effectiveness of the proposed manual, a study might be conducted to compare outcomes using the manual with treatment as usual.

Depending on outcomes, this manual might be applied in training programs for doctoral trainees in psychology, to facilitate training in the area of responding to trauma in an effective and non-harming way, as safety is an important concern among populations who have experienced trauma. Many times these individuals have perhaps

have even attempted to share trauma in previous situations (e.g., among family, with past therapists) and have experienced negative, invalidating reactions. After seeking therapy as a safe place to express these events, it is imperative that trainee therapists are aware about how their responses might impact survivors, and potentially help survivors on their journeys through trauma trajectories. Given the tendency for training programs to offer free or discounted therapy, the community mental health settings in which clinics are set up typically include individuals from low income/SES, low educational backgrounds, clients who might have experienced racism, discrimination, and trauma, abuse or neglect, or poor living conditions/medical care resulting in populations that are at high risk for trauma. If trainee therapists are aware of the impact of their own responses as these clients share with them what many refer to as “unknowable and unshareable experiences,” the opportunities for posttraumatic growth might improve, and the cases in which clinicians respond in a negative or neutral way might be lessened.

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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) (Chadoir & Fisher, 2010; Chelune 1979; Jourard, 1971; Pennebaker, 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; Pennebaker, 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 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	<i>Demographic Disclosure</i>	<i>Personal Disclosure</i>
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	<p>(Code DEMO)</p> <p>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.</p> <p>Examples: “I’m in my third year in a doctoral program in clinical psychology.”</p> <p>“I’m African American” [client’s ethnicity in unknown]</p>	<p>(Code PERS)</p> <p>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.”</p> <p>Examples: “I had to cancel our last session because my son was sick and I couldn’t find a babysitter.”</p> <p>“I saw that on the news.”</p>
<p>Consistent Self-Disclosure (Code SDIS-CON)</p>	<p>(Code SDIS-CON-DEMO)</p> <p>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.</p> <p>Examples: “I’m also working on my doctorate.”</p> <p>“I liken your experience in the army to mine with my children.”</p>	<p>(Code SDIS-CON-PERS)</p> <p>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.</p> <p>Example: “I felt some of the same things when I was going through a death in my family.”</p> <p>“Your experience of camaraderie is deeply reminiscent of my bond with my siblings growing up.”</p>
<p>Inconsistent Self-Disclosure (Code SDIS-INC)</p>	<p>(Code SDIS-INC-DEMO)</p> <p>The therapist makes a verbal statement of a demographic nature that is incongruous with the client’s</p>	<p>(Code SDIS-INC-PERS)</p> <p>The therapist makes a verbal statement of a personal nature that is incongruous with the client’s</p>

	<p>experience following the client’s disclosure. INC would not be coded if the therapist disclosed first.</p> <p>Example: “No, I don’t have kids [client has kids].”</p>	<p>experience following the client’s disclosure. INC would not be coded if the therapist disclosed first.</p> <p>Example: “I haven’t struggled with drug addiction myself and can only imagine what you’re going through.”</p>
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Therapist Expressions of Personal Reactions and Mistakes

Codes	<i>Personal Reactions Disclosure</i> <i>(Code SINV-PERS)</i>	<i>Mistake Disclosure</i> <i>(Code SINV-MIST)</i>
	<p>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.</p> <p>Examples: “I’m struck about something you said.”</p> <p>“And, my gosh.”</p> <p>“I’m feeling very hopeful about the plan we collaborated on.”</p> <p>“We’ve come a long way together.”</p> <p>“I’m feeling sad as you tell me this.”</p> <p>“I’d like to hear more about that.”</p> <p>“I’m thinking about it this way, which maybe might make sense to you also.”</p> <p>“I love that idea.”</p> <p>“I wanted to give you the option of coming in two times a week.”</p> <p>“I know you like to help others”</p>	<p>Therapist disclosures that involve any admission of a mistake by the therapist.</p> <p>Example: “I made a mistake.”</p> <p>“I’m sorry for being late.”</p> <p>“You’re right, maybe I misunderstood what you were trying to tell me.”</p> <p>“I was seriously only two minutes late.”</p> <p>“Sorry about that.”</p>

	<p>“I see you brought something in today.”</p> <p>“I’m concerned about your lack of consistency in attending appointments.”</p> <p>“One thought I had was, going back to the strength thing... [thought is complete/specific]”</p> <p>“I’m worried that you’re not being honest with me.”</p> <p>“I’m very struck by the fact that you saw people get killed yet you feel very little emotion about it.”</p> <p>“I’m disappointed you didn’t attend our last session.”</p> <p>“You’re the most beautiful client.”</p>	
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Therapist Expressions that are Not Otherwise Specified

<i>Code</i>	<i>Description</i>	<i>Examples</i>
<p><i>Other Disclosure (Code NOS/Other)</i></p>	<p>The therapist makes a verbal statement that does not include demographic or personal information about the therapist and does not involve personal feelings/reactions to therapy nor admission of mistakes. “I,” “we,” and “me” are coded for in this category, but not “you” or general niceties (e.g., “Thank you.”). Psychoeducation related to what has been gained through experiences in the mental health field could be coded here. For example, “You may experience flashbacks with PTSD.” Additionally, self-involving statements that refer to the session structure can be coded here. For example, “I think we’re out of time” and “We have two minutes left.” Non-specific and/or incomplete verbal statements are</p>	<p>T: “I’m just really hungry/thirsty.”</p> <p>C: “Did you cut your hair recently? It looks different to me.”</p> <p>T: “I cut it three weeks ago, actually.”</p> <p>T: “I’m not saying let it all out at once...”</p> <p>T: “In that way, we can better help people around us.”</p> <p>T: “That is so typical of what we see in clients who have experienced trauma.”</p> <p>T: “Coz typically it's hard for people to overcome the PTSD without sharing their emotions and feeling them.”</p> <p>T: “Could you turn your phone off?”</p>

	<p>coded here as well as therapy facilitatives (e.g., “I see,” “I understand,” and “Tell me about that”)</p>	<p>It’s very distracting to me.”</p> <p>T: “I see that you got a haircut.”</p> <p>T: “I’m wondering if the journalist could trigger this is you because you don’t have the camaraderie with that journalist?”</p> <p>T: “One thought I had was.... [thought is incomplete/non-specific]”</p> <p>T: “It’s kind of like that I guess...”</p> <p>T: “I see.”</p> <p>T: “I understand.”</p> <p>T: “Tell me about that.”</p>
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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 <i>Gratitude as a broad, general tendency or trait</i> (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 for something or someone.	C: "I am so grateful for my mother, she is amazing."
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 <i>Gratitude as a narrow state</i> (GN).	Description	Examples

<p>Personal gratitude (GN-1)</p>	<p>Personal gratitude is defined as thankfulness towards another person for the benefit he/she has given to this person.</p>	<p>Example: “I feel blessed that Martha wrote that letter of recommendation for me.” Example: “Thank you.”</p>
<p>Gratitude for specific benefits received from a higher power (GN-2).</p>	<p>Personal gratitude towards God or another higher power.</p>	<p>Example: “God has provided me with a wonderful social support system, for which I am so grateful.”</p>
<p>Gratitude outcomes (GN-3)</p> <p>Reciprocation (Secular) (GN-3-RECIP).</p> <p>Prosocial Behavior GN-3-PROSOC</p> <p>Changed perceptions of self and others (GN-3-POS).</p>	<p>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 support as a means of coping - as reflected in the following subcodes.</p> <p>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.</p> <p>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.</p>	<p>Example of GN-3: “When I end my day by counting my blessings, I fall asleep so quickly and feel peaceful”</p> <p>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.”</p> <p>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.”</p> <p>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.”</p> <p>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</p>

	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.	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."
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Client Expressions of Gratitude That Are Not Otherwise Specified

Codes	Description	Examples
<i>Gratitude expressions that are not otherwise specified (Code G-NOS/OTHER)</i>	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
<i>Validating Responses (POS1)</i>	Instances of the therapist-participant expressing a statement (not question) relating understanding and/or acceptance of a client’s thoughts, feelings and behaviors related to the traumatic event. This includes the therapist expressing understanding/acceptance in the form of a reflective statement as well, as long as that reflection is deemed a “complex” reflection; as defined by either paraphrasing, which is when the clinician reflects the inferred meaning of a statement (meaning is added on to what was actually said by the client); or by reflection of feeling, which is when the clinician using paraphrasing to focus on the emotional aspect of the statement; both of which add new meaning to the client’s statement, showing	Understanding: C: [verbalizes feeling upset about traumatic event] T: “I understand how someone would be upset by that” Acceptance: T: “what you went through was difficult,” Validation via Complex Reflection: C: Sometimes when I’m going about my day, it feels like I’m right back in that war zone. T: Even throughout a normal day, you might feel as unsafe as when you were at war and this can be very frightening for you.

	<p>understanding and acceptance of the deeper meaning of what the client has said.</p> <p>[If both a “simple” reflection and validating response, only validating response would be coded, not NEU2- see NEU2 criterion]</p>	
<p><i>Supportive Responses (POS2)</i></p>	<p>Includes encouraging responses of the therapist-participant and/or those that advocate for and empower the client.</p>	<p>Encouraging: T: “I’m glad you’re talking about this,” “Go on,” or “Tell me more”</p> <p>Advocacy/Empowerment: T: “You deserve to be at peace with this,” or “You are very strong for having gotten through this”</p>
<p><i>Empathic Responses (POS3)</i></p>	<p>Those in which the therapist-participant verbalizes using “I statements” how s/he is able to imagine that s/he is the other person who has experienced the situation. Including; expressions related to personal disclosures by the therapist-participant regarding his ability to engage in the experience as if he actually had the feelings, thoughts, and behaviors of the survivor; and expressions related to the therapist inferring or imagining what it would be like to have had those thoughts, feelings, and behaviors of the survivor.</p>	<p>Feelings: T: “I would have been very afraid”</p> <p>Thoughts: T: “I would have been thinking the worst in that situation” “I could imagine that experience would have been difficult”</p> <p>Behaviors: T: “I would have wanted to run away” “I’d imagine that if I were in that situation, I would want to escape.”</p>

Negative Responses (Codes NEG1, NEG2, NEG3)

Codes	Description	Example
<p><i>Invalidating Responses (NEG1)</i></p>	<p>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.</p>	<p>Inappropriate: C: [disclosure of trauma] T: “Oh wow, I’ve never worked with someone who has had such trauma!”</p> <p>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 <i>worst</i> I’ve ever heard,” or “I’ve never heard about anything like this happening to anyone but <i>you</i>, I wonder what that means”</p> <p>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</p>
<p><i>Unsupportive Responses (NEG2)</i></p>	<p>Includes responses in which the person exhibits disbelief over the traumatic event, belittles the client, or reacts with outrage or horror at the survivor, offender, or non-protective social supports of the survivor</p>	<p>Disbelief: T: “Did that really happen to you?” “That seems impossible” or “are you sure it happened the way you’re remembering it?”</p> <p>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”</p> <p>Outrage/horror at survivor: T: Therapist gasps aloud in reaction to traumatic</p>

		<p>disclosure</p> <p>Outrage/horror at offender: T: "I am so angry with the person who did that to you!"</p> <p>Outrage/horror at non-protective social supports: "How could your parents let this happen!? Clearly they are unfit parents!"</p>
<i>Umempathetic Responses (NEG3)</i>	Instances in which the listener is either distracted while the client is speaking; or may be demanding of, or push expectations on, the survivor	<p>Distracted: T: "What were you saying? I'm having a hard time paying attention"</p> <p>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"</p>

Neutral Responses (Codes NEU1, NEU2)

Codes	Description	Example
<i>Clarifying Questions (NEU1)</i>	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?"

<p><i>Reflection/Summaries (NEU2)</i></p>	<p>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.</p>	<p>Simple Reflection: C: And I now become startled whenever I hear a loud noise. T: Hearing loud noises is startling/frightening for you.</p> <p>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...”</p>
--	---	---

APPENDIX B

Client Information Adult Form

ID # _____

CLIENT INFORMATION **ADULT FORM

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

TODAY'S DATE _____

FULL

NAME _____

HOW WOULD YOU PREFER TO BE

ADDRESSED? _____

REFERRED

BY: _____

MAY WE CONTACT THIS REFERRAL SOURCE TO THANK THEM FOR THE REFERRAL?

YES NO

IF YES, PLEASE PROVIDE CONTACT INFORMATION FOR THIS

PERSON/AGENCY

Personal Data

ADDRESS: _____

TELEPHO (HOM _____ BEST TIME TO _____ CAN WE LEAVE A Y
NE E): _____ CALL: _____ MESSAGE? N

(WORK) _____ BEST TIME TO _____ CAN WE LEAVE A Y
K): _____ CALL: _____ MESSAGE? N
AGE: _____ DATE OF ____/____/____
BIRTH _____

MARITAL

STATUS:

MARRIED SINGLE HOW LONG? _____
 DIVORCED COHABITATING PREVIOUS MARRIAGES? _____
 SEPARATED WIDOWED HOW LONG SINCE _____
DIVORCE? _____

LIST BELOW THE PEOPLE LIVING WITH YOU:

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

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

NAME: _____

ADDRESS: _____

TELEPHONE: _____

RELATIONSHIP TO
YOU: _____

Medical History

CURRENT PHYSICIAN: _____

ADDRESS: _____

CURRENT MEDICAL PROBLEMS: _____

MEDICATIONS BEING TAKEN: _____

PREVIOUS HOSPITALIZATIONS (MEDICAL OR PSYCHIATRIC)

DATE

OTHER SERIOUS ILLNESSES

DATE

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

DATE

Educational and Occupational History**HIGHEST LEVEL OF EDUCATION ATTAINED:**

ELEMENTARY/MIDDLE SCHOOL: LIST
GRADE _____

HIGH SCHOOL: LIST
GRADE _____

GED

HS DIPLOMA

CURRENTLY IN SCHOOL? SCHOOL/LOCATION:

VOCATIONAL TRAINING: LIS
TRADE _____

COLLEGE: LIST
YEARS _____

GRADUATE EDUCATION: LI
EARNED _____

CURRENT AND PREVIOUS JOBS:

JOB TITLE	EMPLOYER NAME & CITY	DATES/DURATION
-----------	----------------------	----------------

HOUSEHOLD**INCOME:**

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

OCCUPATION: _____

Family Data

IS FATHER

LIVING?

YES IF YES, CURRENT AGE:

RESIDENCE _____ OCCUPAT _____

(CITY): _____ ION: _____

HOW OFTEN DO YOU HAVE _____

CONTACT?

No

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

AT DEATH: _____ DEATH: _____

CAUSE OF _____

DEATH: _____

IS MOTHER

LIVING?

YES IF YES, CURRENT AGE:

RESIDENCE _____ OCCUPAT _____

(CITY): _____ ION: _____

HOW OFTEN DO YOU HAVE _____

CONTACT?

No

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

AT DEATH: _____ DEATH: _____

CAUSE OF _____

DEATH: _____

BROTHERS AND SISTERS

NAME AGE OCCUPATION RESIDENCE CONTACT HOW OFTEN?

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

NAME	RELATIONSHIP TO YOU	STILL IN CONTACT?
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

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

SELF FAMILY

WHICH OF THE FOLLOWING HAVE FAMILY MEMBERS, ***INCLUDING YOURSELF***, STRUGGLED WITH:

	NO- NEVER HAPPENED	UNSURE	YES- THIS HAPPENED	NO- NEVER HAPPENED	UNSURE	YES- THIS HAPPENED	PLEASE INDICATE WHICH FAMILY MEMBER(S)
SEPARATION/DIVORCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FREQUENT RE-LOCATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EXTENDED UNEMPLOYMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ADOPTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FOSTER CARE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
MISCARRIAGE OR FERTILITY DIFFICULTIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FINANCIAL STRAIN OR INSTABILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
INADEQUATE ACCESS TO HEALTHCARE OR OTHER SERVICES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DISCRIMINATION (INSULTS, HATE CRIMES, ETC.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DEATH AND LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ALCOHOL USE OR ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DRUG USE OR ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ADDICTIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
SEXUAL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PHYSICAL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EMOTIONAL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
RAPE/SEXUAL ASSAULT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HOSPITALIZATION FOR MEDICAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HOSPITALIZATION FOR EMOTIONAL/PSYCHIATRIC PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

Current Difficulties

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

<input type="checkbox"/>	FEELING NERVOUS OR ANXIOUS	<input type="checkbox"/>	DIFFICULTY WITH SCHOOL OR
<input type="checkbox"/>	UNDER PRESSURE & FEELING STRESSED	<input type="checkbox"/>	CONCERNS ABOUT FINANCES
<input type="checkbox"/>	NEEDING TO LEARN TO RELAX	<input type="checkbox"/>	TROUBLE COMMUNICATING S
<input type="checkbox"/>	AFRAID OF BEING ON YOUR OWN	<input type="checkbox"/>	CONCERNS WITH WEIGHT OR I
<input type="checkbox"/>	FEELING ANGRY MUCH OF THE TIME	<input type="checkbox"/>	FEELING PRESSURED BY OTHE
<input type="checkbox"/>	DIFFICULTY EXPRESSING EMOTIONS	<input type="checkbox"/>	FEELING CONTROLLED/MANIP
<input type="checkbox"/>	FEELING INFERIOR TO OTHERS	<input type="checkbox"/>	PRE-MARITAL COUNSELING
<input type="checkbox"/>	LACKING SELF CONFIDENCE	<input type="checkbox"/>	MARITAL PROBLEMS
<input type="checkbox"/>	FEELING DOWN OR UNHAPPY	<input type="checkbox"/>	FAMILY DIFFICULTIES
<input type="checkbox"/>	FEELING LONELY	<input type="checkbox"/>	DIFFICULTIES WITH CHILDREN
<input type="checkbox"/>	EXPERIENCING GUILTY FEELINGS	<input type="checkbox"/>	DIFFICULTY MAKING OR KEEP
<input type="checkbox"/>	FEELING DOWN ON YOURSELF	<input type="checkbox"/>	BREAK-UP OF RELATIONSHIP

- | | | | |
|--------------------------|--------------------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | THOUGHTS OF TAKING OWN LIFE | <input type="checkbox"/> | DIFFICULTIES IN SEXUAL RELATIONS |
| <input type="checkbox"/> | CONCERNS ABOUT EMOTIONAL STABILITY | <input type="checkbox"/> | FEELING GUILTY ABOUT SEXUAL ACTS |
| <input type="checkbox"/> | FEELING CUT-OFF FROM YOUR EMOTIONS | <input type="checkbox"/> | FEELING CONFLICTED ABOUT SEXUAL ACTS |
| <input type="checkbox"/> | WONDERING "WHO AM I?" | <input type="checkbox"/> | FEELINGS RELATED TO HAVING SEX |
| <input type="checkbox"/> | HAVING DIFFICULTY BEING HONEST/OPEN | <input type="checkbox"/> | CONCERNS ABOUT PHYSICAL APPEARANCE |
| <input type="checkbox"/> | DIFFICULTY MAKING DECISIONS | <input type="checkbox"/> | DIFFICULTIES WITH WEIGHT CHANGE |
| <input type="checkbox"/> | FEELING CONFUSED MUCH OF THE TIME | <input type="checkbox"/> | USE/ABUSE OF ALCOHOL OR DRUGS |
| <input type="checkbox"/> | DIFFICULTY CONTROLLING YOUR THOUGHTS | <input type="checkbox"/> | PROBLEMS ASSOCIATED WITH SEXUAL ACTS |
| <input type="checkbox"/> | BEING SUSPICIOUS OF OTHERS | <input type="checkbox"/> | CONCERNS ABOUT HEARING VISION |
| <input type="checkbox"/> | GETTING INTO TROUBLE | | |

ADDITIONAL CONCERNS (IF NOT COVERED ABOVE):

Social/Cultural (Optional)

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

APPENDIX C

Telephone Intake Form

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

ID# _____

Pepperdine Community Counseling Center Telephone Intake Interview

Caller Information

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

WHAT IS YOUR NAME?: _____

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

_____ M F DOB: _____ AGE: _____

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

WHAT IS (CLIENT'S) ADDRESS?: _____

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

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

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

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

WHO DOES (CLIENT) LIVE WITH? SELF OTHERS -

LIST: _____

DOES (CLIENT) HAVE CHILDREN?: _____

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

sample

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

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

Type of Service

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

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

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ID# _____

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

Reason for Referral

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

sample

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

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

CLIENT TOLD LIMITS REGARDING COURT ORDERS? Y N

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

ANY CURRENT THOUGHTS OF HURTING YOURSELF? Y N _____

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

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

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

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

IF SO, PLEASE PROVIDE EXAMPLES: _____

ANY PAST VIOLENCE TOWARDS OTHERS? Y N _____

ID# _____

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

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

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

IF SO, LIST: _____

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

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

WHO IS THE CHILD'S PRIMARY CAREGIVER?: _____

WHO HAS LEGAL CUSTODY OF THE CHILD?: _____

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

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

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

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

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

IS YOUR CHILD COMING VOLUNTARILY/WILLINGLY? Y N

Occupation and Fees

ARE YOU CURRENTLY WORKING OR GOING TO SCHOOL? Y N

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

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

WHAT IS (CLIENT'S) OCCUPATION?: _____

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

Intake Interviewer Checklist



I INFORMED THE POTENTIAL CLIENT OF THE LIMITS OF CONFIDENTIALITY FOR THE PHONE INTERVIEW



I INFORMED THE POTENTIAL CLIENT OF THE NONREFUNDABLE \$25.00 INTAKE SESSION FEE.



I INFORMED THE POTENTIAL CLIENT THAT CLINIC THERAPISTS ARE UNLICENSED GRADUATE STUDENTS WHO ARE SUPERVISED BY LICENSED PROFESSIONALS (CLINICAL PSYCHOLOGISTS AND/OR MARRIAGE FAMILY THERAPISTS)

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ID# _____

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

sample

APPENDIX D

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

Date

Supervisor

APPENDIX E

Treatment Summary

Diagnosis at Termination:

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

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

sample

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

Student Therapist

Supervisor

Date

Date

APPENDIX F

Participant Selection Tracking Sheet

APPENDIX G

Client Consent Form

**Pepperdine University
Counseling and Educational Clinics
Consent for Services**

INITIALS

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

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

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

I understand and agree with the above three statements.

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

Psychotherapy: The first few sessions of therapy involve an evaluation of your needs. At the end of the evaluation phase, a determination will be made regarding whether our services appropriately match your mental health needs. A determination will also be made regarding whether to continue with services at

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

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

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

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

_____ Video/audiotaping

_____ Direct Observation

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

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

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

_____ Written Data

_____ Videotaped Data

_____ Audiotaped Data

OR

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

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

OR

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

Fees: The fee for the initial intake is nonrefundable.

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

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

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

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

- Your therapist may consult with other mental health professionals regarding your case. The consultants are usually affiliated with Pepperdine University. Your therapist may also discuss your case in other teaching activities at Pepperdine, such as class discussions, presentations and exams. Every effort is made to avoid revealing your identity during such teaching activities.
- If the situation involves a serious threat of physical violence against an identifiable victim, your therapist must take protective action, including notifying the potential victim and contacting the police.
- If your therapist suspects the situation presents a substantial risk of physical harm to yourself, others, or property he/she may be obligated to seek hospitalization for you or to contact family members or others who can help.

- If your therapist suspects that a child under the age of 18, an elder, or a dependent adult has been a victim of abuse or neglect, the law requires that he/she file a report with the appropriate protective and/or law enforcement agency.
- If you are involved in a court proceeding and a request is made for information about the services provided to you, the clinic cannot provide any information, including release of your clinical records, without your written authorization, a court order, or a subpoena.
- If you file a complaint or lawsuit against your therapist and/or the clinic, disclosure of relevant information may be necessary as part of a defense strategy.
- If a government agency is requesting the information pursuant to their legal authority (e.g., for health oversight activities), the clinic may be required to provide it for them.
- If the clinic has formal business associates who have signed a contract in which they promise to maintain the confidentiality of your information except as specifically allowed in the contract or otherwise required by law.

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

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

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

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

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

Treatment & Evaluation of Minors:

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

- Over the age of 12, you can consent to services if you are mature enough to participate in services and you present a serious danger to yourself and/or

others or you are the alleged victim of child physical and/or sexual abuse. In some circumstances, you may consent to alcohol and drug treatment.

- Your parents or guardians may, by law, have access to your records, unless it is determined by the child's therapist that such access would have a detrimental effect on the therapist's professional relationship with the minor or if it jeopardizes the minor's physical and/or psychological well-being.
- Parents or guardians will be provided with general information about treatment progress (e.g., attendance) and they will be notified if there is any concern that the minor is dangerous to himself and/or others. For minors over the age of 12, other communication will require the minor's authorization.
- All disclosures to parents or guardians will be discussed with minors, and efforts will be made to discuss such information in advance.

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

_____ and/or _____
Signature of client, 18 or older Signature of parent or guardian
(Or name of client, if a minor)

Relationship to client

Signature of parent or guardian

Relationship to client

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

Clinic/Counseling Center
Representative/Witness

Translator

Date of signing

APPENDIX H

Therapist Consent Form

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OR

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

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

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

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

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

8. I understand that my participation is voluntary and that I may refuse to participate and/or withdraw my consent and discontinue participation in the research project at any time without prejudice to my employment in the GSEP Clinics and Counseling Centers. I also understand that there might be times that the investigators may find it necessary to end my study participation (e.g., if my client withdraws consent for participation in the research study).

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

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

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

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

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

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

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

Participant's signature

Date

Participant's name (printed)

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

Researcher/Assistant signature

Date

Researcher/Assistant name (printed)

APPENDIX I
HIPAA Certification

Health Insurance Portability and Accountability Act of 1996 (HIPAA)



Certificate of Completion

This is to certify that

Courtney Bancroft

*has completed the
HIPAA Training
on*

Monday, May 30, 2011

APPENDIX J

Certificate of Completion
Protecting Human Research Participants



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Courtney Bancroft** successfully completed the NIH Web-based training course “Protecting Human Research Participants”.

Date of completion: 06/7/2011

Certification Number: 700119



APPENDIX K

GPS IRB Approval Notice

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

June 27, 2013

Courtney Bancroft

Protocol #: P0513D04

Project Title: Trainee Therapist Responses to the Discussion of Trauma in Therapy

Dear Ms. Bancroft,

Thank you for submitting your application, *Trainee Therapist Responses to the Discussion of Trauma in Therapy*, 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

