AN OBSERVATIONAL AND EXPERIMENTAL EXAMINATION OF RESPONSES

TO THE DISCLOSURE OF STRESSFUL LIFE EXPERIENCES IN REAL TIME

by

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A DISSERTATION

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This dissertation involves two studies investigating the disclosure of life

experiences in the context of real relationships in real time. Study 1 included 126

university students and community members. Pairs of participants who had known each

other for at least three months were eligible. After participants completed a set of self-

report measures, one member of the pair was randomly selected to disclose an experience

he/she had not previously disclosed to the other member of the pair. A final set of self-

report measures was then completed by each participant. The interaction was videotaped

for coding and analyses. Using the coders' and disclosers' ratings of listeners' behaviors,

we examined the impact of both verbal and nonverbal responses to disclosure and

identified two modifiable behaviors (interruptions and posture) that contributed to

conveying support. Results indicated that leaning backward was associated with more

negative responses to disclosure and moderate levels of interruption were associated with

more supportive responses to disclosure. Study 2 involved similar recruitment procedures to Study 1 and included 220 university students and community members. Pairs of participants were randomly assigned to an experimental or control condition and researchers were blind to condition. After completing a series of self-report questionnaires, the person randomly assigned to the discloser role was asked to describe an experience of mistreatment not previously disclosed to the other participant. This interaction was videotaped. Following this, participants completed post-disclosure questionnaires. Then, psychoeducational materials regarding either healthy lifestyle improvements (control condition) or supportive listening techniques (experimental condition) were distributed, followed by a quiz on these materials. A second experience of mistreatment was disclosed and a final set of post-disclosure questionnaires was completed. Results indicated that the psychoeducational materials were effective in enhancing supportive responses to disclosure such that listeners in the experimental condition demonstrated significantly fewer unsupportive behaviors than listeners in the control condition. Listeners who started with high levels of unsupportive behaviors benefitted the most from the psychoeducational materials. Although there are several limitations of these studies and additional research with more diverse samples is needed, the findings represent an important preliminary step in research.

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CHAPTER I

GENERAL INTRODUCTION

Recovery from negative or stressful life experiences frequently involves telling others what happened. While disclosure can serve a variety of purposes (e,g., self-expression, self-clarification, social control, social validation, emotional support, catharsis, tangible aid (Ahrens, Campbell, Ternier-Thames, Wasco, Sefl, 2007; Parker & Parrott, 1995), the impetus is often solicitation of social support. Without disclosure, it is difficult for support to be provided. However, it is thought that responses to disclosure, rather than the act of disclosure in and of itself, are strong predictors of outcomes following disclosure. In fact, positive social support in response to disclosure is frequently associated with a multitude of mental health benefits (e.g., Coker, Smith, Thompson, McKeown, Bethea, & Davis, 2002). Although this relationship has been well established empirically, less is known about what constitutes a supportive response and how supportive and unsupportive behaviors can be distinguished from one another. In addition, it is uncertain how best to educate the general public in responding supportively to disclosures of negative life experiences. Accordingly, some of these areas have been acknowledged as important directions for future research (Ahrens et al., 2007; Ryan & Solky, 1996), and represent main objectives of the present set of studies.

While traumatic events (e.g., physical, emotional, and sexual abuse) constitute one type of negative life experience, there are a variety of negative life experiences that

are not only common in the general population (see Lantz, House, Mero, & Williams, 2005), but also are often distressing (e.g., bereavement, betrayal of trust, loss of an important relationship). Thus, in the present set of studies we aimed to examine a variety of negative life events that are perceived and/or experienced as distressing by the individuals reporting them. Although traumatic disclosure is a focus of the literature review that follows, for the purposes of the present studies, disclosure of negative life experience was conceptualized broadly and included, but was not limited to, the disclosure of traumatic events.

The Disclosure of Trauma

Modes of Traumatic Disclosure

The term "disclosure" is rather broad, and thus researchers in the trauma field vary in their interpretations and usage of it. In order to refine the way in which traumatic disclosure is defined, Alaggia (2004) explored ways of conceptualizing traumatic disclosure and associated patterns and processes. Through a qualitative investigation comprised of intensive interviews with sexual assault survivors, Alaggia (2004) identified several disclosure categories that have been defined in prior research, including purposeful, accidental, and prompted/elicited. Additional "types" of disclosure that were identified via her research included "rapid, delayed, spontaneous, withheld, intentional, explicit and vague" (Alaggia, 2004, p. 1214).

The intensive interviews revealed that the most commonly reported disclosure type was purposeful (42%) (Alaggia, 2004). Elicited/prompted disclosures (e.g., through therapy, investigations) followed, and frequently occurred in adulthood rather than

childhood. Accidental disclosures (e.g., discovered by another person through witnessing or medical examinations) occurred least often (8%). The following categories were developed in order to account for the remaining disclosure patterns: behavioral (62.5%; deliberate use of nonverbal cues such as anger outbursts, running away, tantrums or indirect verbal cues such as "Can you come home early?" or "Do you have to go to work?" as a means of disclosure), intentionally withheld (approximately 25%; unrelated to recall of abuse, often abuse was denied when directly questions were asked), and triggered disclosure (29%).

Based on these results, a model of types of disclosure with four categories was developed: purposeful (including verbal disclosure, indirect verbal hints, and deliberate behavioral cues), behavioral (including both intentional and unintentional non-verbal cues and symptoms), intentional withholding (including deliberate denial, accidental third-party discovery, and elicited/prompted), and triggered disclosure of delayed memories. Although we do not distinguish between these types of disclosures in the present studies, we do examine both verbal and behavioral (e.g., tone of voice, facial expressions) aspects of disclosure.

The Benefits of Disclosure

Benefits of both verbal (e.g., Lepore, Ragan, & Jones, 2000) and written (e.g., Hemenover. 2003) disclosure of a variety of experiences have been indicated in prior research; more specifically, traumatic disclosure has been associated with a variety of positive psychological benefits. Ruggiero et al. (2004), for instance, found that prevalence of PTSD symptoms and major depressive episodes were significantly higher

in long-delay disclosers compared to non-disclosers and short-delay disclosers, even after controlling for demographic and abuse-related variables. Thus, waiting a longer time to disclose was associated with worse outcomes than waiting a shorter time to disclose and not disclosing.

Several theories have been advanced to explain reasons underlying the benefits of disclosure (Bradley & Follingstad, 2001; Pennebaker & Chung, 2007). While many of these theories were not specifically developed to explain the benefits of traumatic disclosure, several have been applied both to the disclosure of trauma and the disclosure of negative or stressful life experiences more generally. Most often, disclosure is viewed as a therapeutic way of describing and processing experiences. One theory, for instance, suggests that disclosure is beneficial in that it allows for emotional expression and acknowledgement of emotional experiences (Pennebaker & Chung, 2007).

Other researchers posit that the inhibition required for non-disclosure taxes physiological resources and, in turn, causes stress (Bradley & Follingstad, 2001; Pennebaker & Chung, 2007). Following from this logic, once disclosure occurs the need for inhibition may decrease, thereby reducing physiological arousal.

A third model used to conceptualize the benefits of disclosure is Leonard's (1996) "social exchange theory" (in Paine & Hansen, 2002). In a sense, this theory can be thought of as a "cost-benefit" analysis of disclosure processes. For instance, a child that is being abused might reduce his or her distress by perceiving oneself as deserving of this treatment. In addition, the perpetrator may promise the child safety, presents, and protection of siblings and/or the family unit, in return for silence. Taken together, these

promises and the perception that the abuse is deserved, result in a seemingly "fair" relationship or exchange. Thus, the "cost" of disclosure may outweigh the "benefit," likely resulting in nondisclosure. According to this theory, the "benefits" of disclosure are very individualized and are often considered prior to the disclosure, thereby exerting an influence on the decision to disclose. In addition, the individual's perception of whether the disclosure was beneficial may be considered in the context of the "costs" of the disclosure.

A fourth theory posits that the specific form of disclosure used in many exposure therapies for trauma survivors is a way of re-conditioning the anxiety often associated with traumatic memories (Bradley & Follingstad, 2001; Pennebaker & Chung, 2007). In other words, through disclosure, a person can habituate himself/herself to anxiety-provoking stimuli. This often requires repeated detailed description of emotions and sensations related to the trauma, either verbally and/or in writing, such that a coherent trauma narrative that integrates previously fragmented memories and emotions, can be created. It is thought that through the creation of this narrative certain PTSD symptoms are ameliorated (Riggs, Cahill, & Foa, 2006, Shipherd, Street, & Resick, 2006). Freyd (1996) has similarly hypothesized that transforming "sensory" memories into a more sharable form (e.g., the language of a coherent and sharable narrative) might also alleviate symptoms of posttraumatic distress. Relatedly, it has been theorized that when disclosure occurs in a coherent way, a person may develop greater insight, which may allow shifting of perspective and reframing of harmful cognitions (Pennebaker & Chung,

2007). In these theories, construction of a coherent narrative is key in producing positive outcomes of disclosure.

Lastly, it has been suggested that the benefits related to disclosures that occur in the context of relationships may be attributable to social support factors, rather than the act of disclosure itself; for instance, if a person's disclosure is accepted by members of the social support network, this may facilitate the development of a positive view of oneself (Bradley & Follingstad, 2001). This is consistent with prior research demonstrating that responses to disclosure are important in predicting outcomes following disclosure (e.g, Ahrens et al., 2007; Coker et al., 2002; Figueiredo et al., 2004; Lepore et al. 1996). Although these theories implicate different mechanisms underlying the therapeutic nature of disclosure and offer different conceptualizations of the important components of disclosure, all support the notion that disclosure can have beneficial outcomes.

Delayed Disclosure

Although prior research suggests that disclosure can be beneficial (e.g., Ruggiero et al., 2004), between 30 and 80% of survivors purposefully do not disclose childhood sexual abuse (CSA) before adulthood (in Alaggia, 2004). In fact, average disclosure latencies of 3 to 18 years from abuse onset have been reported (in Alaggia, 2004). Other research suggests that anywhere from 26% (Kogan et al., 2004) to 31% (Coker et al., 2002) of survivors have not disclosed their trauma(s) outside of the research context.

While it appears that our responses to traumatic disclosure are extremely important regardless of the amount of time it may take a person to disclose, it may be

especially important for survivors who wait a long time. It is possible, for instance, that there is greater stigma associated with disclosing abuse that occurred a long time ago compared to abuse that occurred more recently, as people may be less likely to believe the disclosure (e.g., because of assumed memory errors over time, lack of evidence, etc.).

The fact that longer disclosure delays are associated with closer relationships to perpetrators (Foynes, Freyd, & Deprince, 2009), reflects another characteristic of abuse that may make the disclosure less likely to be believed or more likely to be stigmatized by others. At the same time, waiting a long time to disclose may serve as a protective coping mechanism that may allow survivors to continue depending on perpetrators, and/or to remain relatively emotionally and/or physically safe; it also prevents the receipt of negative reactions to disclosure (Ahrens, 2006). Negative reactions to disclosure may range from unsupportive verbal or nonverbal responses to violence (Gielen et al., 2000). Thus, the act of disclosure may represent a certain readiness or willingness to heal that was not safe or even possible shortly after the abuse occurred. In light of these possibilities, it is important that disclosure be met with supportive, accepting, and validating responses.

Recipients of Disclosure

A large body of research suggests that recipients of disclosure are less likely to be mental health or social service professionals and more likely to be friends and family members (e.g., Coker et al., 2002; Fisher, Daigle, Cullen, & Turner, 2003; Paine & Hansen, 2002; Ullman & Filipas, 2001). For instance, in one study survivors reported that initial confidants were most often friends (36%), mothers (35%), and other relatives

(8%) (Kogan, 2004). Another study indicated that the first recipients of disclosure were friends (38.2%) and family members (22.5%) (Ahrens et al., 2007). This research underscores the importance of teaching the most common recipients of disclosure, family members and friends, how to be supportive when traumas are disclosed.

Factors Thought to Predict Delayed Disclosure

A variety of factors thought to predict delayed disclosure have been examined in prior research, including age (e.g., Foynes et al., 2009; Kogan, 2004; Paine & Hansen, 2002; Ruggiero et al., 2004)), gender (Foynes et al., 2009; Paine & Hansen, 2002), abuse severity (Foynes et al., 2009; Kogan, 2004; Paine & Hansen, 2002; Ruggiero et al., 2004), abuse duration (Paine & Hansen, 2002; Ruggiero et al., 2004), method of coercion (Paine & Hansen, 2002; Ruggiero et al., 2004), and relationship to perpetrator (Foynes et al.; Kogan, 2004; Paine & Hansen, 2002; Ruggiero et al., 2004). While many of these findings are mixed, one of the strongest predictors of longer disclosure delays is a closer relationship to the perpetrator (Foynes et al., 2009; Kogan, 2004).

In terms of research examining the association between age and patterns of disclosure, some findings suggest that younger children (i.e., under the age of 7) are unlikely to disclose immediately (Kogan, 2004). This may be due to a lack of the cognitive or language resources required for disclosure, less persistent memories of abuse, and/or greater dependence on perpetrators of abuse (Freyd, Deprince, & Zurbriggen, 2001). Patterns in whom survivors decide to tell may also change with age. As survivors get older, for instance, relationships to peers become more important and likelihood of peer disclosure increases (Kogan, 2004). In fact, prior research indicates

that while children ages 7 to13 years are most likely to tell an adult, adolescents ages 14

to 17 years are most likely to tell peers. Type and content of disclosures also vary as a

function of age such that disclosures made by younger children are more likely to be

accidental, whereas disclosures made by older children were more likely to be

purposeful. Younger children are also more likely to be vague and give less detail in

their disclosures (Paine & Hansen, 2002).

Interesting findings regarding the association between disclosure and abuse

severity have also been demonstrated. A literature review by Paine and Hansen (2002),

for example, suggested a u-shaped relationship between disclosure and abuse severity,

with survivors at both ends being less likely to disclose. Other research indicates that

characteristics often used to judge abuse severity, such as penetration and fears for one's

life, are associated with a greater likelihood of disclosure to adults (Kogan, 2004).

Although Kogan (2004) concluded that abuse characteristics (e.g, age at abuse onset, fear

for one's life, penetration) were important in predicting whom a victim would tell,

relationship to perpetrator was the strongest predictor of delayed disclosure. Importantly,

it has been discovered that many survivors who experience abuse that is *not* characterized

by perpetrator threats or force are also nondisclosers (50%) (Ruggiero et al., 2004),

suggesting that increased abuse severity is not a consistent predictor of disclosure delays.

Reasons for nondisclosure or delayed disclosure may include children's beliefs

that they were willing participants/coconspirators, fear of blame or negative

treatment/evaluation, concerns regarding homosexuality or not being believed, desire to

keep family or perpetrator safe, fear of hurting others, fear of punishment, concern for

well-being of perpetrator (in Paine & Hansen, 2002), and familial values of obedience (Somer & Schwarczberg, 2001). Another concern impeding disclosure may be fear that it will not help; unfortunately, it appears that in some cases, this is true. In fact, prior research has demonstrated that in many cases abuse continues for a year or more following disclosure to a parent (52%), and many initial disclosures (17%) do not culminate in any sort of psychological intervention (in Paine & Hansen, 2002). Taken together, this body of research illustrates that some trauma survivors are less likely to disclose, or to wait longer to disclose, than others, and that oftentimes when disclosure occurs, proper support is not provided.

The findings from prior research regarding predictors of delayed and nondisclosure can serve as a foundation for tailoring our supportive responses to meet the needs of individuals. For instance, our efforts to provide supportive responses to those survivors with close relationships to their perpetrators can incorporate the knowledge that these survivors may wait longer to disclose, often for a functional purpose, so that there is increased attention to respecting the risks and difficulties in disclosing this kind of trauma.

<center>The Importance of Responses to Disclosure</center>

The effects of disclosure are largely contingent upon the quality of responses received (e.g., Ahrens et al., 2007; Lepore et al., 2000). Not only may the type of responses be relevant (e.g., offering tangible aid, refusing to help), but also the manner in which these responses are delivered (cold and detached vs. warm and empathic) (Ahrens et al., 2007). In fact, it is possible for support attempts to be well intentioned, but to be

experienced as negative or harmful, nonetheless (Campbell, Ahrens, Wasco, Sefl, & Barnes, 2001). Thus, it is important to note that disclosure in and of itself may not necessarily predict more beneficial outcomes.

The importance of social responses in predicting outcome following disclosure of negative experiences has been documented in disclosure of sexual trauma (Ahrens et al., 2007; Ullman, 2007; Ullman & Filipas, 2001; Ullman & Filipas, 2005; Ullman; Townsend, Filipas, & Starzynski, 2007), breast cancer (Figueiredo, Fries, & Ingram, 2004; Lewis et al., 2001), abortion (Major, Cozzarelli, Sciacchitano, Cooper, Testa, & Mueller, 1990), bereavement (Lepore, Silver, Wortman, & Wayment, 1996), and interpersonal violence (Coker et al., 2002). More specifically, negative reactions to disclosure predict negative mental health outcomes such as reduced quality of life, role limitations, social functioning deficits, increased symptoms of depression and PTSD. In fact, research demonstrates that if interpersonal violence is disclosed and social support received, women demonstrate almost a 50% reduction in risk of mental health outcomes such as substance abuse, anxiety and depression, PTSD, suicidal ideation and attempts, as well as improved physical health (Coker et al., 2002). Interestingly, it has also been observed that disclosing and receiving a negative reaction predicts worse psychological outcome than both disclosures met with supportive responses (Figueiredo et al., 2004; Lepore et al., 1996; Ullman & Filipas, 2005; Ullman et al., 2007) and nondisclosure (Major et al., 1990). This suggests that disclosure alone is not sufficient for benefit; the recipient must offer emotional support, which in turn, may have other positive effects, such as helping the survivor improve coping responses (Coker et al., 2002).

In the medical literature, empathy is implicated as an important tool in facilitating patient disclosure and enhancing the doctor-patient alliance (Halpern, 2001). It has also been demonstrated that when physicians are attuned to patients' emotions, patients' trust of their physicians increases, which in turn, can predict treatment adherence (in Halpern, 2001). Importantly, it has been noted that perceptions of physicians' behaviors (e.g., physician's level of care), rather than satisfaction with these behaviors, predict long-term psychological adjustment in breast cancer patients; furthermore, it has been suggested that this effect is stronger for certain classes of symptoms (e.g., PTSD) as compared to more general forms of distress (Mager & Andrykowski, 2002).

Research with oncology patients suggests that when oncologists respond to indirect or direct expressions of patient emotion with "continuers" or statements that encourage (rather than discourage) continued disclosure and expression of emotion, patients not only have less anxiety and depression but also are more satisfied with and more likely to adhere to treatment (Pollak et al., 2007). Examples of these "continuers" include labeling emotion (e.g., "I wonder if you are feeling sad about the test result), empathizing with and validating emotion (e.g., "Many of my patients feel discouraged when they aren't seeing the response they want, so it makes sense that you feel this way"), showing respect (e.g., "I applaud you for your courage in all of this) and support (e.g., "I will be with you until the end"), and encouraging patients to elaborate on their emotional experience (e.g., "Tell me more about what is upsetting you") (Pollak et al,, 2007, p. 5749). Unfortunately, these kinds of empathic responses were not common. In fact, when patients indirectly or directly expressed negative emotions, a situation that is

viewed as an "empathic opportunity" for oncologists, 41% of oncologists *never* responded with continuers. In addition, in response to empathic opportunities, oncologists used continuers in only 27% of patient cases. Results also indicated that prior training in communicating with patients did not predict their responses. This underscores the importance not only of training physicians to respond empathically, but also in finding a way of training physicians that actually results in behavioral change and translates into an ability to respond empathically to patients.

Additional research that utilizes the perspective of breast cancer survivors has demonstrated that physicians exhibiting certain behaviors or characteristics (e.g., physicians that acknowledge patient emotion, ask encouraging questions, seem to want what is best for the patient, care for the patient, include the patient in decision-making) are viewed as more compassionate, and that this "enhanced compassion" is associated with decreases in anxiety levels compared to both prior levels and control group levels (Fogarty, Curbow, Wingard, McDonnell, & Somerfield, 1999). Moreover, the expression of "enhanced compassion" took approximately 40 seconds on average (Fogarty et al., 1999). Given the prior research demonstrating that empathic opportunities exist, but that empathic responding is rare, the finding that compassion can be conveyed in such a short amount of time emphasizes how cost-effective and time-efficient it can be to express compassion in a way that can be beneficial for patients (Fogarty et al., 1999).

While the body of research regarding responses to disclosure has generated important findings, the majority has been in the form of retrospective, self-report methodologies. Fewer studies have implemented designs in which disclosure is elicited,

and observed, in the research context (e.g. Dindia, Fitzpatrick, & Kenny, 1997; Fritz,

Nagurney, & Helgeson, 2003; Lepore, Fernandez,-Berrocal, Ragan, & Ramos, 2004;

Lepore et al., 2000; Lutgendorf & Antoni, 1999; Pistrang, Barker, & Rutter, 1997), a

technique that often allows for the manipulation of various constructs and inference of

causality. While some of these studies have examined important aspects of self-

disclosure (e.g., individual differences, reciprocity, gender, depth of relationship) (e.g.,

Dindia et al., 1997), only two of these studies have examined the impact of *negative*

responses to disclosure in a laboratory setting where there is actual human interaction,

instead of relying solely on retrospective accounts of disclosure (e.g. Lepore et al., 2004;

Lepore et al., 2000), and the findings have been mixed.

In one study, participants watched a slide and video presentation of the

Holocaust, and were then assigned to either a "no-talk" control condition in which they

remained alone and did not talk, or one of three experimental conditions in which they

disclosed their thoughts and feelings about the Holocaust presentation. These

experimental conditions included talking in a room alone, talking to a validating

confederate who shared a similar reaction to the stimulus, or talking to an invalidating

confedereate who shared a dissimilar reaction to the stimulus (Lepore et al., 2000).

Upon reexposure to the stressor two days later, participants in the "talk alone" and

"validating confederate" conditions were significantly lower in perceived stress and

intrusive thoughts than participants in the "no talk" control condition. Interestingly,

participants in the "invalidating confederate" condition fared neither better nor worse

than participants in the three other conditions ("no talk," "talk alone," and "validating

confederate"). The authors propose that the receipt of an invalidating response may have "diluted" the benefits of talking, and that some people may have benefited from an invalidating response (i.e., most people experienced the stimulus as negative or stressful, and hearing that someone reacted dissimilarly may have helped reframe the experience in a more positive way) whereas others did not. Of note, invalidating confederates were rated as significantly less knowledgeable about the Holocaust and less interesting than validating confederates, suggesting that participants may not have considered their opinions very seriously, or may have even discounted them, especially since the confederates were strangers rather than significant others (Lepore et al., 2000). The authors' acknowledge the study's limited ecological validity given the nature of the stressor (e.g., time-limited exposure, content likely low in personal significance and level of direct threat to participants) and the disclosure interaction (e.g., brief, scripted response, between two strangers without a real relationship).

In a similar study, participants watched a video clip of a gang rape scene, and were then assigned to one of four experimental conditions (no talking, talking alone, talking to a "validating" confederate and talking to a "challenging" confederate) (Lepore et al., 2004). The challenging confederate differed from the validating confederate in both verbal and nonverbal behavior. More specifically, the challenging confederate maintained a more neutral position and did not make consistent eye contact with the participant. Following the disclosure, the challenging confederate reacted in a more detached fashion and presented the participant with a different view of the video; for instance, the challenging confederate would make comments such as ''I don't know

exactly what happened in the video, but from what you said, I don't think everyone

would _____, "I can't really see why you would feel _____from watching the

video." "I could really imagine myself sitting and watching the scene, but I wouldn't

have thought _____," "…When I was listening to you talk about the video, I found it

hard to keep my mind on what you were saying; I was thinking about all the stuff I have

to do today'' (p. 347).

Upon re-exposure to the video, participants who disclosed to a "challenging"

confederate demonstrated the largest decreases in distress. In light of this surprising

finding, the authors proposed that receiving an alternate perspective may have allowed

participants to distance themselves from the stressor, either by believing they had

overreacted or that the victim in the video had provoked the rape. It is also possible that

participants assumed that they *should* be upset following this stressor, and in turn, did not

report the decreased distress they may have experienced after interacting with the

validating confederate. Interacting with the "challenging" confederate, on the other hand,

may have given participants the impression that feeling less distressed was an appropriate

response (Lepore et al., 2004). As in the aforementioned study, participants in this study

disclosed their reactions to someone else's experiences. Since participants did not

disclose stressors they had experienced directly, it is difficult to know whether these

results generalize to more personal disclosures.   In addition, disclosing in this context

may not parallel disclosures that occur in the context of intimate and/or important social

relationships.

Definitions of Social Support

Although there may be individual variation in what is considered supportive, the fact that disclosure is often essential for survivors to receive emotional, legal, or financial assistance in their recovery underscores the importance of cultivating a supportive environment in which such disclosures can occur. As constituents of supportive responses and strategies for educating others on how to be supportive are identified, this research can inform the creation of such an environment.

Social support is defined in numerous ways. In prior research, social support has often been defined in terms of the nature of the social support network (e.g., number of people in the social network, degree of intimacy between the self and social network members, formal and informal sources of social support) or the type of support provided (e.g., emotional, instrumental, informational) (Hogan, Linden, & Najarian, 2002). Broadly speaking, Ryan and Solky (1996) suggest that in order for social support to be considered as such, it must meet one or more of a person's psychological needs, such as relatedness, autonomy, and competence. For instance, effective social support may meet a person's need for relatedness via the strengthening of a connection or by demonstrating the extent to which the person is loved and valued. It might also honor and respect a person's autonomy. Ryan and Solky (1996) further posit that what distinguishes an authentically supportive relationship from one in which the support is more superficial (e.g., casual interactions) is the ability of a person to empathize, acknowledge and accept our experiences, which in turn, allows us more freedom to be and express ourselves.

In defining social support, some research suggests that it is important to ask survivors to identify the kinds of reactions to disclosure that are helpful or supportive (and also harmful) rather than assuming that certain responses are helpful (Ahrens et al., 2007). In other words, understanding and gaining insight into the perspective of the discloser is crucial. For instance, in examining first disclosures of rape, Ahrens et al. (2007) identified a few instances in which positive reactions were considered detrimental. That is, when recipients of disclosure reacted empathically, sometimes disclosers felt worried about the recipients' well-being or felt the need to comfort the discloser at the expense of meeting their own needs for support. Relatedly, other research has demonstrated that well-intended support attempts can be experienced as hurtful, or are often not able to meet survivor's needs or expectations (Ahrens, 2006). In other cases, people may receive negative reactions from others, yet are able to dismiss or remain unaffected by these responses because the amount of distress they have experienced as a result of the trauma makes them feel numb and immune to these reactions (Ahrens et al., 2007). In still other cases, people may have difficulty evaluating whether or not responses are supportive (Ahrens et al., 2007). These findings suggest that what is considered supportive should, in large part, be evaluated on the basis of what is considered supportive to the individual disclosing. Ahrens et al., (2007) suggest explicit training for both professionals and the community regarding interacting with survivors in a "supportive and empathic manner" (p. 47).

Prior research focusing on survivors who stopped disclosing for a substantial period of time after receiving a negative reaction from the first person to whom they

disclosed, revealed that the negative reactions often resulted in doubts about the effectiveness of future disclosures, increased feelings of self-blame, and questioning whether what happened was actually considered rape (Ahrens et al., 2006). It is important to note that not disclosing again may serve a protective function (Ahrens, 2006); in other words, by not disclosing, survivors may prevent negative reactions, which in turn, might prevent some of the negative consequences associated with negative reactions, such as increased PTSD symptoms. This illustrates the importance of studying first disclosures, as we attempted to do in the present set of studies.

<center>Prior Research on Social Support Interventions</center>

While an abundance of prior research has documented the importance of social support, the effectiveness of various social support interventions is less clear. This is in large part due to the variety of interventions that have been studied and the variety of populations in which they have been examined. In order to elucidate significant research findings in this area, and provide guidance for gaps in the current literature, Hogan et al. (2002) conducted a review of social support interventions. In order to facilitate comparisons across studies, the following criteria were used to create meaningful distinctions between interventions: 1) Is the intervention delivered in a group or individual format? 2) Is the intervention intended to provide direct support (e.g, providing emotional or informational support) or to increase the quality of the support network (e.g, helping people develop skills to improve their support network)? 3) Who is the "support person" being targeted or examined in the study (e.g., family member or mental health professional)? Although overall conclusions were difficult to make given the wide range

of variability within and across these three dimensions, the authors concluded that social support interventions are promising, given that approximately 83% of the studies reviewed reported some benefits of the intervention relative to control groups or no intervention.

Generally, common methodological limitations included lack of measures of social support, small sample sizes (e.g., n<15 per condition), inattention to random assignment, inclusion of descriptive statistics only rather than inferential statistics, and overreliance on self-report data. In addition to addressing these limitations in future research, the authors also recommended incorporating members of the participants' natural support network into social support interventions either by directly including them or focusing on improving those relationships specifically. Furthermore, they suggest that lack of social support is more about the failure of the support network to be supportive than it is about the individual's ability to foster supportive relationships or articulate his/her needs. Following this logic, the improvement of social support within the natural support network via skills training may be more helpful than interventions that provide direct support. The present set of studies attempts to address all of these issues by including a measure of social supportive behaviors that has been psychometrically evaluated, substantial sample size, random assignment to condition, descriptive and inferential statistics, and an observational and experimental methodology that allows for self-report data, video-recording, pre- and post- measures of support and functioning, and data from multiple sources (both members of the dyad and a researcher).

Prior Research on Empathic Responding and Listening

The importance of empathic responding and listening has been implicated in many areas of research, including, but not limited to, social work (e.g., Forrester, Kershaw, Moss & Hughes, 2008; Hansen, Resnick, & Galea, 2002), therapy (e.g., Barkham & Shapiro, 1986; Elliott, Barker, Caskey, & Pistrang, 1982; Haase & Tepper, 1972), medical encounters (e.g., Bylund & Makoul, 2005; Fogarty et al., 1999; Halpern 2001; Mager & Anrykowski, 2002), business (e.g., Rautalinko & Lisper, 2004), academic settings (e.g., Imhof, 1998) and teacher-supervisory relationships (e.g., Taylor, Cook, Green, & Rogers, 2001). While there is a substantial body of research examining listening theory (e.g., Janusik, 2008), there is considerably less empirical research regarding effective ways of teaching listening skills, as well as the constituents of effective ways of listening, studied in relational/dyadic contexts and as defined by their impact on the person disclosing.

In Study 2 we sought to explore and teach a form of supportive listening that is, in a sense, a combination of selected literature regarding empathic responses and listening. More specifically, this kind of listening is most similar to the concepts of "benevolent listening" and "active listening" that have been coined by others.

In 2000, a member organization of "Befrienders International," "La Main Tendue," began a campaign to promote "benevolent listening" in the French-speaking region of Switzerland with a public research component (Befrienders International, 2000). In an attempt to address the high rate of suicide in Switzerland, La Main Tendue emphasized listening as one of the first steps in helping others; this involved billing

posters with the message "To lend an ear is to lend a hand: Listening in everybody's

business," collaborating with the media to publicize the campaign via programs and

articles, direct mailings to households that included instructions for ways of

implementing "benevolent listening," and an interdisciplinary conference. The term

"benevolent listening" was used to describe a kind of listening that "is based on not

judging others and focuses on the person you are listening to" (Befrienders International,

2000, pg. 53); it also involved refraining from giving advice and conveying empathy.

Through this campaign, La Main Tendue sought to raise awareness of the importance of

listening in "everyday life" and the positive effects of listening on mental health, with the

intention of encouraging others to become invested in listening to others and reducing

behaviors that are not conducive to listening.

The term "active listening" was first introduced by Gordon (1970) and derived

from the reflective listening strategy utilized in Rogers' (1951) client-centered therapy (in

Rautalinko & Lisper, 2004) as a way of conveying empathy. Gordon attempted to apply

the concept of "active listening" to a broad range of situations that extended beyond

counseling (in Rautalinko & Lisper, 2004). "Active listening" is often referred to as a

communication skill that includes both verbal (e.g., paraphrasing, reflecting feelings,

using exploring questions) and nonverbal behaviors (e.g., appropriate facial expressions

and eye contact, involved/engaging gestures and posture) (Fassaert, van Dulmen,

Schellevis, & Bensing, 2007; Robertson, 2005).

While the term "active listening" and many variants of this term have been

utilized in several disciplines, its use in the medical field and its application to the doctor

patient relationship largely informed the current research. This research area was chosen as a basis for the current psychoeducational component because of its specificity; however, to the best of our knowledge, only a few studies have examined the effectiveness of specific intervention components (Pollak et al., 2007) or trainings (Ancel, 2006) empirically. Further, these studies have suffered from methodological limitations such as small sample sizes and lack of control groups. While there have been a few interventions in other non-medical areas that have garnered empirical support (e.g., Hatcher, Nadeau, Walsh, Reynolds, Galea & Marz, 1994; Taylor et al., 2001), most of the interventions in medical (e.g., Cordova, Ruzek, Benoit, & Brunet, 2003) and non-medical (e.g., Hansen, Resnick & Galea, 2002; Resnick, 1998) areas have not been evaluated empirically. This underscores the importance of the current set of studies.

CHAPTER II

INTRODUCTION – STUDY 1

This exploratory pilot study was meant to help us learn more about the process of

disclosing an event for the first time *as it occurs in real time*, and the types of verbal and

nonverbal responses given by close others upon such disclosures.

Summary of Purposes and Goals

While it has been previously demonstrated that supportive responses are

important predictors of positive outcome, less is known about what constitutes a

supportive response; thus, deconstructing supportive responses was one main goal of

Study 1. In addition, the majority of previous disclosure research consists of either

retrospective report (e.g., Major et al., 1990, Paine & Hansen, 2002; Smith et al., 2000),

which is subject to recall bias, or disclosure to researchers or confederates (e.g. Lepore et

al., 2000; Lepore et al., 2004), which compromises ecological validity. Thus, the fact that

this study examined disclosure in the context of real relationships makes it an

improvement over prior examinations of disclosure in more artificial contexts.

Since recipients of disclosure are more frequently friends, partners, or family

members (Ahrens et al., 2007; Leaper, Carson, Baker, Holliday, Myers, 1995; Ullman,

1996; Ullman & Filipas, 2001), participants in the current study disclosed to people they

identified as friends. Other research examining disclosure in friendships (Leaper et al.,

1995) suggests that participants can often feel like they do not have anything "new" to

discuss when presented with a broad topic. This provided a rationale for the way in which we focused the topics of disclosure in the present studies, by asking participants to disclose something to the other participants that they had not disclosed to that particular person before. This also allowed us to study "first disclosures," as their importance has been implicated in prior research (e.g., Ahrens, 2006).

In addition, it has been suggested that prior research is lacking in that it fails to address the perspective of both members of the dyad; thus, in this study we collect information of both participants' impressions of the interaction (Pistrang, Barker, & Rutter, 1997). We also attempted to address the limitations of prior research that focus solely on verbal reactions to disclosure. Since the integration of nonverbal and verbal data has been suggested (Leaper et al., 1995), we attempted to quantify both verbal and nonverbal responses to disclosure. Thus, this naturalistic dyadic study attempted to circumvent many of the methodological limitations of prior research.

Summary of Objectives

In summary, through Study 1 we aimed to do the following:

1. Capture the processes underlying disclosing life events for the first time to close others, *as the disclosures occur*.

2. Examine the types of verbal and nonverbal responses given following disclosure and identify characteristics that constitute a "supportive response."

3. Investigate the impact of factors such as relationship quality, trauma symptoms, and prior disclosure experiences on current disclosure processes.

CHAPTER III

METHOD – STUDY 1

Participants

The sample was comprised of 126 university students and community members. For the purposes of the study, distinctions were not made between students and community members. Accordingly, the same demographic information was collected from each participant, precluding the possibility of examining differences between these groups. In future research, such data should be collected so that the demographic characteristics of each group can be compared.

Recruitment began with the Department of Psychology's Human Subjects Pool at the University of Oregon, which is comprised mostly of students enrolled in introductory psychology classes. For their participation, participants were given academic credit to partly fulfill a course requirement. In order to participate, each Human Subject Pool participant was required to find a friend, whom he or she had known for at least three months, who would also be willing to participate during the same time; this individual was compensated monetarily if he/she was not eligible for credit. Participants from the Human Subjects Pool did not self-select into the study based on knowledge of the content; rather, participants were selected for the study based on schedule availability and friend availability. In addition, participants with a history of trauma were not targeted as part of the recruitment process; thus, while almost two-thirds of our sample did report a history of trauma (see "Descriptives" section for more details), this was not a requirement

for participation in the study. Prior to running the study, human subjects approval was granted by the University of Oregon's Institutional Review Board.

Approximately 63% of the participants were female. In terms of the gender composition of the pairs of participants, in approximately 51% of the pairs both participants were female, in approximately 26% one participant was male and one was female, and in approximately 22% of the pairs both participants were male. Ages ranged from 18 to 33, (M=19.70, SD=2.33), and the majority identified as European American only (76.9%). Approximately 97% were born in the United States, and approximately 81% reported that both of their parents were born in the United States.

<div align="center">Measures</div>

<div align="center">*Initial Self-Report Measures*</div>

Demographics Questionnaire

This questionnaire was created in the Dynamics Lab and includes questions about age, gender, ethnic identification, birthplace of participant and participant's parents, language fluency, disability, highest level of education completed, number of hours of sleep the night prior, mood (described below) and anxiety (described below). (See Appendix A).

Global Anxiety and Mood

These questions were part of the demographics questionnaire mentioned above. To assess for global changes in mood and anxiety, two questions were administered prior to and following the disclosure interaction. They were as follows: "How worried/anxious/stressed are you feeling about life events (for example, school, work,

finances, friends, family, etc.)?" (response options included "not at all, slightly, an average amount, more than average, and extremely;") "How would you describe your general mood?" (response options included "great, good, average, poor, and horrible") (See Appendix A).

Betrayal Trauma Inventory (BTI)

A shortened version of the BTI (BTI; Freyd, DePrince, & Zurbriggen, 2001) was combined with a measure (described below) assessing social reactions following child sexual abuse (CSA) disclosures (CSA Supplement, Ullman & Filipas, 2005) (See Appendix B). Although not all participants reported prior experiences of trauma (our recruitment strategies did not target trauma survivors in particular), this measure was included in the packet of questionnaires that all participants completed. If participants did not experience a particular event, they skipped to the next page (see Appendix B). Following each endorsement of an abusive experience (perpetrated by either very close or not very close others), participants were also asked to answer questions related to perpetrator characteristics and whether others knew the experience occurred, either via the participant's disclosure of the experience or another way. If the participant endorsed that an experience had occurred and that others knew about the experience, he/she was asked to complete the CSA Supplement, which followed BTI questions for each event experienced, to assess others' reactions to the disclosure and/or event discovery.

The original BTI was adapted from an existing, well-validated measure (Abuse and Perpetration Inventory (API); Lisak, Conklin, Hopper, Miller, Altschuler, & Smith, 2000). In creating the BTI, Behaviorally-defined items were drawn from the API (13

physical abuse and 20 sexual abuse items), and 3 sexual abuse items were added to the

BTI. Twelve behaviorally-defined emotional abuse items were also added to the BTI

(e.g., "Before you were age 16, someone told you that if you did not do what they

wanted, someone you love (for example, a sibling or pet) would be hurt or killed").

Thus, the BTI assesses physical, emotional, and sexual abuse perpetrated by both very

close (traumas with high betrayal – HiBTs) and not very close others (traumas with low

betrayal – LoBTs). The BTI has been used in several other studies (e.g., Becker-Blease,

Freyd, & Friend, 2005; Freyd et al., 2001; Freyd, Klest, & Allard, 2005) and adheres to

previous recommendations of screening for multiple types of trauma and multiple events

within those types (DePrince, 2001; Green et al., 2000). Further support for the use of

the BTI comes from prior research indicating a high level of agreement (62-77%)

between the BTI and another trauma inventory, the Brief Betrayal Trauma Survey

(BBTS; Goldberg & Freyd, 2006), despite wording differences across the measures

(DePrince, 2001). It has also been suggested that the BTI assesses "important

dimensions of childhood trauma in ways that people can understand and respond to

consistently" (Deprince, 2001, p.74).

CSA Supplement

The CSA supplement (Ullman & Filipas, 2005) is an exploratory measure created

to capture reactions particularly relevant to disclosure of child sexual abuse. This

measure was initially intended to supplement the Social Reactions Questionnaire

(Ullman, 2000), which was developed for disclosure of sexual assault occurring in

adulthood. The CSA supplement is a 12-item measure, with each item rated on a 5-point

Likert scale with responses ranging from 0 ("never") to 4 ("always). Sample items include, "reacted to your story with disbelief" and "helped stop the abuse from happening again." In prior work the CSA supplement was administered separately for reactions received in childhood and for those receive in adulthood, with internal consistency of α = .70 and α = .73, respectively.

In our study, participants completed the CSA supplement following each endorsement of an abusive experience on the BTI (See Appendix B). Thus, the CSA supplement was completed for all abusive experiences separately, including those that occurred both before and after the age of 18. In accordance with prior research (Ullman, 2000), scores on all of the 12 items related to a single abuse experience were summed. Then, for each individual participant, separate averages were calculated across all abuse types (i.e., emotional, physical, and sexual) within perpetrator type (HiBT and LoBT), generating two numbers per participant that represented an "average" level of negative reactions to the disclosure of these traumas: one representing the average level of negative reactions the survivor experienced in response to the disclosure of HiBTs and one representing average negative reactions to the disclosure of LoBTs. Higher scores represented more negative reactions to disclosure.

Relational Health Index-Peer Version (RHI-P)

The RHI-P (RHI-P; Liang, Tracy, Taylor, Williams et al., 2002) is a 12-item measure used to assess three dimensions of relational health, or "growth-fostering" peer relationships: engagement, authenticity, empowerment/zest. Confirmatory factor analyses conducted by other researchers have demonstrated that while these three

dimensions are strongly correlated, they do represent different constructs (Liang et al., 2002). Internal consistency for each subscale, as well as the composite score, has been shown to be adequately high (ranges from $\alpha = .73$ to $\alpha = .85$). Moderate convergent validity with the Mutual Psychological Development Questionnaire (MDPQ-P; Genero, Miller, Surrey, & Baldwin, 1992), the friend support subscale of the Multidimensional scale of Perceived Social Support (Zimet, Dahlem, Zimet, & Farley, 1988), and the support and depth subscales of the Quality of Relationships Questionnaire (QRI-P; Pierce, Sarason, Sarason, Solky-Butzel, & Nagel, 1997) has been demonstrated, as well as a less strong, but significant, negative correlation with the conflict scale of the QRI-P. In terms of concurrent validation, it has been demonstrated that both the composite and subscale scores are weakly and positive related to Rosenberg's Self Esteem Scale (Rosenberg, 1965), and moderately and negatively related to the Los Angeles Loneliness Scale (Rusell, Peplau, & Cutrona, 1980).

Trauma Symptom Checklist (TSC-40)

The TSC-40 (TSC-40; Elliott & Briere, 1992) is a 40-item instrument measuring the extent to which posttraumtic symptoms are generally experienced. Items are ranked according to frequency, and responses are rated on a 4-point likert scale ranging from 0 ("never") to 3 ("very often"). The TSC-40 is comprised of six symptom subscales including anxiety, depression, dissociation, sexual abuse trauma index, sexual problems, and sleep disturbances. Sample items include anxiety attacks, nightmares, feelings of not being in one's own body, and trouble getting along with others. The TSC-40 is scored by summing responses, resulting in scores ranging from 0 to 120, which higher scores

indicating greater frequency of traumatic symptomatology. The measure has been shown to have adequate internal consistency (Elliott & Briere, 1992), as well as good construct (Gleaves & Eberenz, 1995), concurrent (Gold, Milan, Mayall, & Johnson, 1994) and convergent validity (Gold & Cardeña, 1998; Zlotnick & Shea, 1996). The measure has also been used in university samples (Gleaves, Williams, Harrison, & Cororve, 2000).

Pre-disclosure Open-ended questions

A small set of open-ended questions was created specifically for the pre-disclosure portion of this study.

Life Experiences

In order to prepare participants for the disclosure interaction (even though they did not yet know the details of this procedure), participants were asked to write down five events or experiences that would be the *most* difficult to talk to someone else about and to write down three events or experiences they had not yet told the other participant about and/or aspects of an event or experience that they had not yet told the other participant about.

Relationship

To gather additional information on their relationship with the other participant, each participant was asked the following open-ended questions: 1) "For how long have you known your friend?" 2) "On average, how much time do you spend together each week?" 3) "In the space below, please describe your relationship with the other participant."

Post-Disclosure Questionnaires

The post-disclosure questionnaires for both participants are included in

Appendices C and D.

Social Reactions Questionnaire (SRQ)

The SRQ (SRQ; Ullman, 2000) is a 48-item self-report measure used to assess

both positive and negative reactions a person receives from others following the

disclosure of rape. In the present study, a shortened 25-item version of the SRQ was used

in order to address time constraints and eliminate items that seemed more specific to

reactions following disclosure of rape that may not have generalized to the variety of

disclosures in the present study. A total of 25 items were chosen to ensure that all 7

subscales were represented (3 control, 3 blame, 6 emotional support/belief, 3 egocentric,

4 treat differently, 3 distraction, and 3 information support/tangible aid items). After the

disclosure interaction, both the discloser and listener used the SRQ either to rate their

partner's responses to their disclosure (Participant A) or to rate themselves on their

responses to their partner's disclosure (Participant B) on a 5 point Likert Scale ranging

from 0 ("never") to 4 ("always") indicating the extent to which they had experienced

each reaction. Ultimately, an 11-item version of the measure was for coding purposes

(see below).

Prior research examining the psychometric properties of this measure utilized a

principle components analysis that revealed 7 subscales, 5 assessing negative reactions

(blame, distraction, egocentric, control, treat differently) and 2 assessing positive

reactions (emotional support/belief and information support/tangible aid) (Ullman, 2000).

High internal consistency (ranging from $\alpha = .77$ to $\alpha = .93$) and adequate test-retest

reliability (ranging from $\alpha = .64$ to $\alpha = .81$) have also been demonstrated (Ullman, 2000).

In that same study, all of the negative reaction subscales were significantly and positively

correlated with one another (rs ranging from .15 to .72), and the two positive reaction

subscales were significantly and positively correlated with one another (r=.58) (Ullman,

2000). In terms of convergent validity, positive reaction subscales have been

significantly and positively correlated with Rosenberg's Self Esteem Scale (Rosenberg,

1965), and negative reaction subscales have been significantly and negatively correlated

with Rosenberg's Self Esteem Scale and significantly and positively correlated with

Foa's Posttraumatic Stress Diagnostic Scale (Foa, Mulnar, & Cashman, 1995) (Ullman,

2000). Concurrent validity has been demonstrated by significant correlations between

closed- and open-ended SRQ items for all subscales except for distraction (Ullman,

2000).

Post-disclosure Open-ended Questions

These questionnaires were created for the post-disclosure portion of this study in

order to gather more in-depth information about the disclosure interaction. Participant A

(discloser) was asked the following questions: "How did you choose which event or

experience to tell the other participant? (i.e. it was the easiest/most difficult to disclose,

you had/hadn't told many people about this event or experience before, etc.)"; "How do

you feel this experience was overall?"; "Have you told other people about this

event/experience before?" In order to gain a global measure of the discloser's experience

(GAD), his/her response to this question was coded on a 5-point rubric,similar to that

used in previous studies (e.g. Klest & Freyd, 2007), (1 representing very positive experiences, and 5 representing very negative experiences). Participant B (listener) was asked the following: "Has someone ever told you about an event/experience like this before?" "How do you feel this experience was overall?" "If someone has told you about a similar event/experience before, do you feel your reaction was: similar, different, don't remember/hard to say?" Both participants were also asked to assess their global level of mood and worry with the same questions administered in the pre-disclosure questionnaires (see above).

Coding System Development & Evaluation

A coding system and accompanying brief instructions document were created for this study such that the disclosure interactions could be quantified. This initial coding system included ratings of the listeners' posture (3 items), verbal and nonverbal interruptions made by the listener (1 item), and various types of listeners' responses to the disclosure as measured by the SRQ and a global assessment measure (see below). The listener's responses to disclosure were rated by a 6-item "global assessment" we constructed for the study (administered twice), as well as the same 25-item version of the SRQ that both participants used following the disclosure interaction to rate the listener's responses. Thus, disclosers, listeners, and coders all rated the listeners' responses to disclosure using the 25-item version of the SRQ (although ultimately, for purposes of interrater reliability, the SRQ that coders used was reduced from 25-items to 11-items, which is described in more detail below). Disclosers' posture was also rated (3 items), as well as their willingness to disclose as time went on (3 items on the "global assessment,"

administered twice). Thus, the initial coding system consisted of 50 items (see Appendix E).

Two undergraduate coders with prior research experience assisted with this project for academic credit. Sixteen videos that could not be used for various reasons (e.g., missing self-report data, researcher error, incomplete video data) were used by coders to practice using the coding system and achieve interrater reliability. Preliminary examination of the videos revealed that coding the entire 20-minute conversation was not necessary, as many partners had finished discussing the initial topic after about 6-8 minutes. Thus, we decided to begin by coding only the first 8 minutes of the interaction.

Coders began by watching the same four tapes at separate times. They were instructed to watch the first eight minutes of the video and to rate the "global assessment" and "SRQ" sections of the coding system. They then watched the video a second time in order to code both participants' posture at various time points, and a third time to record the number of times the listener interrupted the discloser. Nonverbal and verbal behaviors were judged to be interruptions based on their effect on the discloser. For instance, if a listener made an utterance (e.g., "hmmm", asked a question) or movement (e.g., nodded, fidgeted) that did not appear to derail or distract the discloser, it was not considered an interruption. If however, such behaviors appeared to discourage the discloser from continuing, forced him/her to change topic, or otherwise appeared disruptive or distracting in some way, they would be coded as interruptions. Following this, coders completed the "global assessment" a second time (this section was included twice to determine whether global assessments would differ based on the order in which

they were rated, perhaps because of bias resulting from other ratings). Lastly, coders were asked to record any experiences and impressions they felt were important to note (e.g., what they noticed, what the coding system seemed to be missing/not assessing). Coders then met with the principal investigator for a discussion; certain items were clarified and suggested changes to the coding system were made accordingly (e.g. coding time reduced from 8 minutes to 6 minutes, 5 items dropped because of difficulty in rating them based solely on observation).

Using the revised coding system, each coder then coded 6 more videotapes. They later met with the principal investigator to discuss any ratings that were not within 2 points of one another and to address any difficulties in ratings items in this context. Of note, coders mentioned difficulty with the rating categories: disagree, slightly disagree, neutral, slightly agree, and agree. In addition, the coders reported that several of the items were rarely observed; many of these items seemed irrelevant to the types of disclosure that were made in the study and/or did not appear to make sense in the observed contexts (e.g., wanting to seek revenge against the perpetrator would not be a relevant reaction to a disclosure in which there was no perpetrator or the perpetrator was deceased); this called into question whether a rating of "disagree" would really distinguish between relevant behaviors that were not observed, and those that were not observed, yet did not seem relevant in the given context. There was also some confusion about what the neutral category meant (e.g., a combination of slightly agreeing and slightly disagreeing, a behavior not being applicable). Because the participants had used the same responses to

rate the same items, we did not want to change the response options so as to facilitate comparisons between respondents (coders, disclosers, and listeners) in later analyses.

Before making any changes to the coding system based on the coders' experiences, interrater reliability analyses of these 6 videotapes were conducted. When calculating intraclass correlations (ICCs), there needs to be some variability within coders and across participants, as a lack of considerable variation in the participant means may generate inconclusive or even misleading results (e.g., ICCs may be low even if coders used the same exact ratings.) Thus, in constructing or developing items for coders to rate, it is important to choose items in which variation across participants is expected (i.e., from a statistical perspective, if the ratings of an item are consistently the same for everyone, it is not a good item to include.) Viewing plots of the variability of the items illustrated that several items did not have variability across participants or within coders, likely because of the abovementioned issue regarding item relevance. These items with minimal variability paralleled those items that coders had thought were irrelevant or extremely difficult to code in most of the videotapes. Thus, these 9 items were dropped. The interrater reliability analysis also revealed that the coders demonstrated a similar level of reliability on both global assessment sections of the coding system (for first section, average ICC = .723, for second section, average ICC = .716). Therefore, we decided to have coders complete this section only once and to include it at the end of the document. We decided to include this section at the end of the document since by that time the coders would have reviewed the tape several times, and therefore possibly may have been more able to make a global assessment of the interaction.

Using the second revision of the coding system, coders rated 6 more videotapes. Reliability analyses revealed that trained coders had achieved high interrater reliability on the coding system (global assessment ICC = .808; SRQ ICC = .871; interruptions ICC = .701; for posture, average Kappa: .551, all $ps<.05$).

The final coding system included 25 items and involved rating the first 6-minutes of the interactions for both participants' posture (leaning left, right, backward, and forward, and sitting upright) at three time points throughout the interaction (when the researcher left, 3 minutes into the disclosure, and 6 minutes into the disclosure, generating 6 items in total), and a frequency count of both nonverbal and verbal interruptions made by the listener (one item), and listeners' responses to disclosure on various types of responses to disclosure using the 11-item version of the SRQ and the 5-item global assessment measure (GAC) (See Appendix F for Final Coding Document). Disclosers' willingness to disclose as time went on was also rated by 2 items in the GAC. Coders were asked to watch the first 6 minutes of the tape and then complete the SRQ for the listener's behavior. They were then asked to record both participants' postures as soon as the researcher left the room, 3 minutes into the tape, and 6 minutes into the tape. They then watched the first 6 minutes a final time in order to record the number of interruptions made by the listener. After this, the GAC section was completed.

Reliability analyses were conducted throughout the coding process to determine whether coders remained reliable. A final reliability analysis was conducted after both coders had coded all videos. This revealed high interrater reliability (global assessment ICC = .950; SRQ ICC = .872; interruptions ICC = .978; for posture, Kappa = 0.893, all

ps < .001). In order to generate an index that reflected both coders' ratings, an average was taken for each item rated for each pair, resulting in one final set of coder ratings (e.g., for each pair, the ratings for coder 1 were averaged with the ratings for coder 2 for each item). Averages of coders' ratings were also calculated within each measure (e.g., average score on SRQ and average score on GAC as rated by coders).

Procedure

Sessions lasted for approximately 90 minutes. Participants first completed the series of self-report (BTI, CSA Supplement, RHI-P, TSC-40, global mood and anxiety) and open-ended questionnaires (regarding their relationship and prior life experiences) mentioned above. Following the completion of these measures, each participant was randomly assigned to a "discloser" or "listener" condition. The discloser was instructed to disclose an event or experience to the "listener" that he/she has never told this friend before; both participants were asked to respond as naturally as possible, as they would in everyday circumstances. The interaction was videotaped for 20 minutes for subsequent coding and analysis. Following the disclosure activity, participants completed the post-disclosure questionnaires (SRQ and open-ended questions about the disclosure interaction) described previously.

CHAPTER IV

RESULTS AND DISCUSSION – STUDY 1

Descriptives

The correlations between exposure to traumas with high betrayal (HiBTs),

exposure to traumas with low betrayal (LoBTs), negative social reactions to BTs, trauma

symptoms, relational health, and mood change from pre- to pos-disclosure, can be found

in Table 1.

Table 1
Correlation Table - Study 1 - Descriptives

Variable	1	2	3	4	5	6	7
1. HiBT[a]	–	.291**	.875**	.062	.141	.156	-.014
2. LoBT[b]		–	.118	.388	.169	-.035	-.078
3. Responses HiBT[c]			–	.298	-.065	.311	.355
4. Responses LoBT[d]				–	-.193	-.093	.307
5. Trauma Symptoms[e]					–	.065	-.215*
6. Mood Change[f]						–	.209*
7. Relational Health[g]							–

Note. [a]HiBT = number of traumas high in betrayal reported on the BTI. [b]LoBT = number of traumas low in betrayal reported on the BTI. [c]Responses HiBT = average level of negative reactions to disclosure of HiBT reported on the CSA supplement. [d]Responses LoBT = average level of negative reactions to disclosure of LoBT reported on the CSA supplement. [e]Trauma Symptoms = score on TSC-40. [f]Mood Change = mood change from pre- to post-disclosure. [g]Relational Health = score on the RHI-P.

*$p < .05$. **$p < .01$.

Approximately 65% of the sample indicated that they experienced at least one type of traumatic event on the BTI, with 40.2% of the sample indicating that they experienced at least one form of emotional, physical, or sexual abuse. In addition, 32.3% indicated that they experienced at least one type of trauma with high betrayal (HiBT) and 18.9% indicated that they experienced at least one type of trauma with low betrayal (LoBT). Number of types of HiBTs reported on the BTI was significantly and positively correlated with number of types of LoBTs reported ($r = .291.$, n=127, p<.01, R^2=.085). Although a substantial portion of the sample indicated on the BTI that they had a prior trauma history, not everyone disclosed these traumas during the disclosure interaction in the present study. That is, a broad range of disclosure topics (that the discloser had not told the listener about previously) was typically listed by participants and these topics were not limited to traumatic events.

For each traumatic event reported on the BTI, participants were asked whether that event had been disclosed outside of the study, and if so, to rate the kinds of reactions they received upon disclosure. These reactions were assessed via the 12-item CSA supplement that followed each endorsement of an abusive experience on the BTI. As mentioned previously, for each individual participant, separate averages were calculated across all abuse types within perpetrator type, generating two scores per participant that represented an "average" level of negative reactions to the disclosure of these traumas: one representing the average level of negative reactions the survivor experienced in response to the disclosure of HiBTs and one representing average negative reactions to the disclosure of LoBTs.

The number of types of HiBTs experienced (e.g., various forms of emotional, physical, and sexual abuse; experiences that occurred before and after the age of 18) was significantly positively associated with negative responses to disclosures of such traumas ($r = .875$, n=29, p<.01, $R^2=.766$). A similar nonsignificant trend was found for the number of types of LoBTs experienced and negative responses to their disclosures ($r=.388$, n=15, p>.05). Comparisons could not be made between participants who experienced HiBTs and LoBTs since most people experienced both (i.e., 5 people experienced only LoBTs).

Higher levels of trauma symptoms were associated with relationships characterized on the RHI by lower levels of relational health ($r=-.215$, n=126, p<.05, $R^2=.046$) (data on trauma symptoms were collected for all participants regardless of prior trauma history). In addition, relationships high in relational health were associated with more positive changes in mood following the disclosure ($r = .209$, n=126, p< .05, $R^2=.044$).

The correlations between ratings of the disclosure interactions made by disclosers, listeners, and coders can be found in Table 2. Average scores on the 25-item SRQ were positively and significant correlated with average scores on the condensed 11-item SRQ for both listeners ($r=.939$, n=49, p<.001, $R^2=.882$) and disclosers ($r=.866$, p<.001, n=46, $R^2=.750$). Since the condensed 11-item SRQ was also used by coders, and the correlations between this version and the other were high, this was the version used in subsequent analyses. Average scores on the 11-item SRQ rated by disclosers was also significantly and positively correlated with the GAD ($r=.382$, n=44, p<.05) and the GAC

(r=.484, n=48, p < .01). Average coder ratings on the GAC and the 11-item SRQ were

also significantly and positively correlated (r=.341, p<.05). Although disclosers' and

listeners' ratings on the 25-item SRQ were positively and significantly correlated (r=.378,

n=46, p<.05), this finding only approached significance for the 11-item version (r=.258,

p=ns).

Table 2
Correlation Table - Study 1 - Disclosure Ratings

Variable	1	2	3	4	5	6	7
1. 25-item SRQ - L[a]	–	.378**	.939**	.288*	-.075	.216	.072
2. 25-item SRQ - D[b]		–	.338*	.866**	.147	.451**	.319*
3. 11-item SRQ - L[c]			–	.258	.001	.201	.133
4. 11-item SRQ - D[d]				–	.149	.382**	.484**
5. 11-item SRQ - C[e]					–	.174	.341*
6. GAD[f]						–	.087
7. GAC[g]							–

Note. [a]25-item SRQ - L =listeners' self-ratings of reactions to disclosure using 25-item
SRQ. [b]25-item SRQ - D = disclosers' ratings of listeners' reactions to disclosure using
25-item SRQ. [c]11-item SRQ - L = listeners' self-ratings of reactions to disclosure
using 11-item SRQ. [d]11-item SRQ - D = disclosers' ratings of listeners' reactions to
disclosure using 11-item SRQ. [e]11-item SRQ - C = coders' ratings of listeners'
reactions to disclosure using 11-item SRQ. [f]GAD = global assessment of the
disclosure interaction as rated by disclosers. [g]GAC = global assessment of the
disclosure interaction as rated by coders.

*p < .05. **p < .01.

Most of the disclosers in the study experienced no change in worry (65.3%) or

mood (69.4%) following the disclosure interaction. A moderate number experienced

improvements in worry (27.8%) and mood (22.2%), while a small minority experienced

worsening of worry (6.9%) and mood (8.3%). These same patterns persisted for

disclosers with histories of trauma. It is important to note that because trauma survivors

were not recruited specifically for the study, there was a low number of participants

randomly assigned to the discloser role that had various kinds of trauma histories (e.g.,

high and low betrayal), precluding further analyses on the relationship between trauma

history and disclosures in the current study. Although participants did not necessarily

disclose traumatic experiences, the possibility exists that prior traumatic disclosures and

the responses received to those disclosures influenced the disclosures in the present

study. Since more extensive histories of trauma high in betrayal have been associated

with less benefit from written disclosure interventions in prior research (Klest & Freyd,

2007), it is important that the relationship between trauma history and verbal disclosures

be examined.

<center>Analyses of Listeners' Negative Reactions to Disclosure</center>

A limited number of people were leaning forward or to the side (left or right)

during the disclosure interaction, whereas the majority was leaning backward or sitting

upright. Thus, a narrower set of posture groupings was created to generate more

equivalent cell sizes. Because a category combining leaning forward with other positions

did not seem to make sense conceptually, and because so few people were leaning

forward (approximately 2), we excluded these pairs from the posture analyses. We then

created a "neutral" category referring to upright or leaning to the side, and a "backward"

category. An independent samples t-test revealed that negative reactions, as rated by

coders global assessments on the GAC, were found when listeners were leaning backward (M=2.57, SD=.9) toward the end of the disclosure, compared to listeners sitting in neutral positions (upright, left, and right) (M=2.09, SD=.45), t(21.782)=-2.133, p<.05, two-tailed, Cohen's D=.675 (See Figure 1). A nonsignificant trend toward parallel findings was found when examining disclosers' global assessment of listeners' responses (as indicated by scores on the GAD) p>.05, Cohen's D=-.319 (See Figure 1). Posture ratings at the beginning and during the middle of the disclosure were not significantly related to negative reactions, though nonsignificant trends tended to be in similar directions (i.e., more negative responses when listeners were leaning backward), ps>.05. There was also no significant relationship between posture positions and listeners' ratings of their own responses, as measured by their responses on the 11-item version of the SRQ. Perhaps this suggests that disclosers and coders are picking up on one aspect of the interaction that listeners are not; that is, listeners may not consider their posture when rating how the interaction went, whereas disclosers and coders may.

An independent samples t-test revealed that listeners who were leaning backward (M=13.31, SD=8.53) in the beginning of the disclosure tended to interrupt more than those in neutral positions (M=9.63, SD=6.03), though this difference only approached significance, t(45)=-1.728, p=.091, two-tailed, Cohen's D=-.497. Taken together, the significant associations between listeners leaning backward and interrupting more and between listeners leaning backward and responding more negatively to the disclosure may suggest that these behavioral indices either convey less support or are associated with other factors that demonstrate less support.
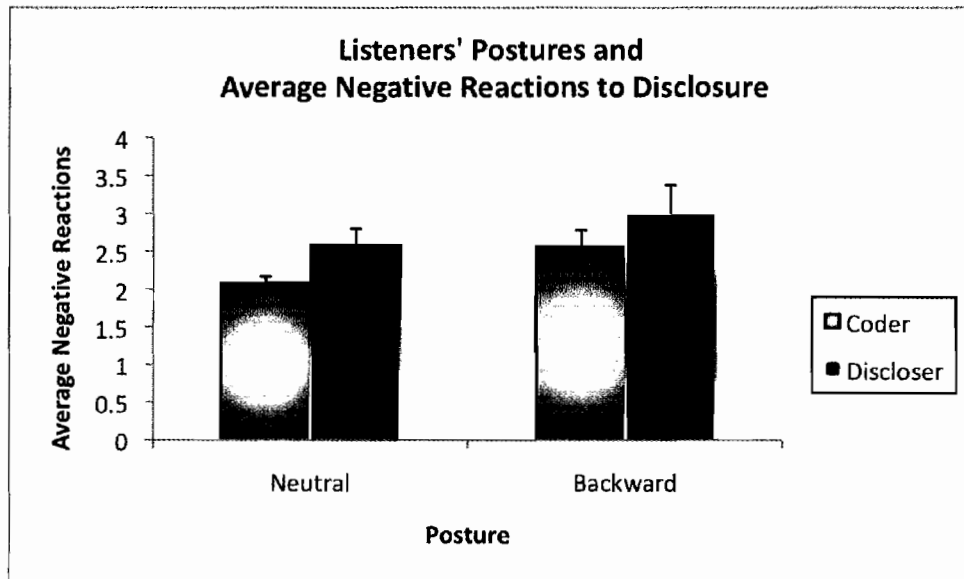
Figure 1. Mean level of negative reactions to disclosure (+*SEM*) as rated by both coders (*n* = 51) and listeners (*n*= 43) for listeners with posture rated as leaning backward or neutral toward the beginning of the disclosure interaction.

Because the distribution of the average number of interruptions made by listeners was bimodal, various transformations (e.g., log, square root, and reciprocal) were ineffective in generating a normal distribution that maintained the continuous nature of this variable. Thus, based on the non-normal distribution, three categories were created to facilitate analyses: low (0-6), moderate (6.1-11.5), and high (11.6-32) levels of interruptions. A one-way ANOVA revealed a significant between subjects effect of level of interruptions and GAC ratings, $F(2)=3.967$, $p<.05$. Based on a graphical depiction of the data, a post-hoc trend analysis was conducted, revealing a significant quadratic relationship between interruptions and coders' global ratings of support (GAC), $F(1)=7.547$, $p<.01$ (See Figure 2). Based on coder ratings, the u-shaped relationship between number of interruptions and negative reactions suggests that moderate levels of interrupting are best. Perhaps very infrequent interruptions convey disinterest or

disengagement, whereas very frequent interruptions convey disregard for one's disclosure

needs or the pursuit of one's own agenda. Though nonsignificant, the data for disclosers

(GAD) indicated a different relationship between interruptions and reactions to disclosure

such that minimal and moderate levels of interrupting were associated with similar levels

of negative reactions to disclosure and high levels of interrupting were associated with

the most supportive responses. This suggests that perhaps coders and disclosers perceive

this relationship differently.

Interruptions and Coders' Ratings of Listeners' Negative Reactions to Disclosure
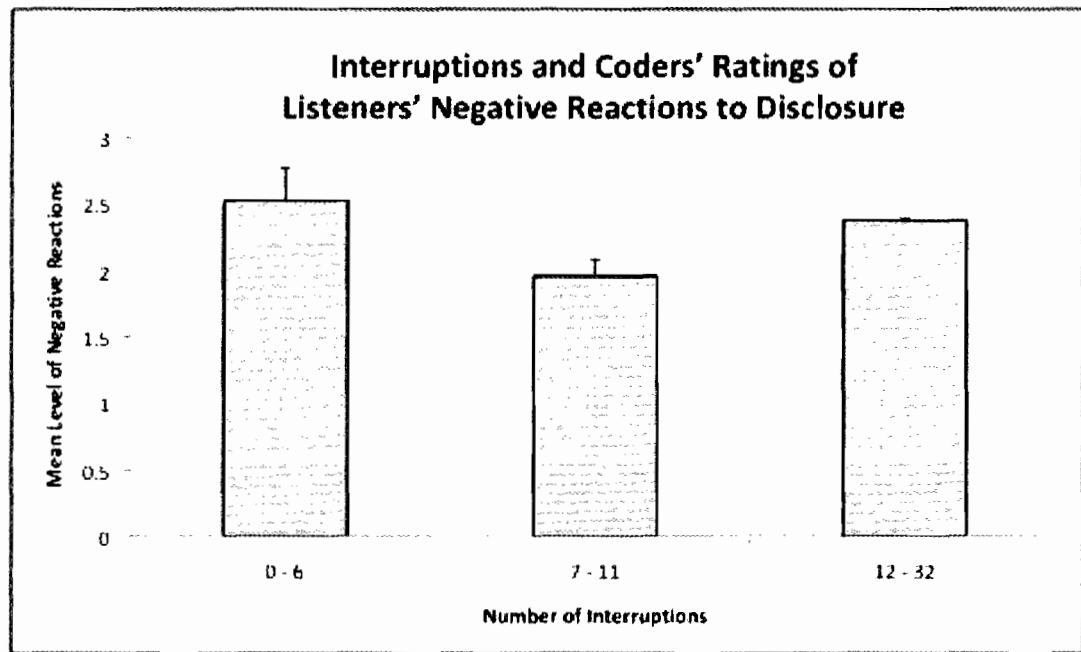
Figure 2. Mean level of listeners' negative reactions to disclosure (+*SEM*) for listeners
who interrupted the discloser 0 - 6 times ($n = 16$), 7 - 11 times ($n = 20$), and 12 – 32 times
($n = 17$) during the disclosure interaction.

In summary, these findings provide a foundation for research clarifying nonverbal

and verbal characteristics of unsupportive and supportive responses to first disclosures of

stressful life experiences. The fact that these results are derived from real disclosures

between people in real relationships increases the generalizability of this research; in

addition, we have examined the disclosers' perceptions of the interaction, which allows

us to take these perceptions into account in identifying the constituents of supportive

responses. The fact that both posture and number of interruptions are modifiable, and that

both of these behaviors were shown to impact disclosers' perceptions of listeners'

responses, offers the impetus for continuing to investigate their relationship to perceived

support in future research. Thus, the examination of these behaviors was included in

Study 2.

CHAPTER V

INTRODUCTION – STUDY 2

Study 2 was designed as an experimental examination meant to build upon

findings of Study 1. Our primary goal was to utilize an experimental design to assess

whether, and how, empathic listening skills and supportive responses to disclosures can

be taught to the general public.. As mentioned previously, while traumatic events

constitute one type of negative life experience, there are a variety of negative life

experiences that are not only common in the general population (see Lantz, House, Mero,

& Williams, 2005), but also are often distressing. As such, people often tell others (e.g.,

friends, partners, family members) what happened, which introduces the possibility that

negative responses could be provided and in turn exacerbate a person's distress. Thus, in

the present set of studies we aimed to examine the disclosure of a variety of negative life

events that are perceived and/or experienced as distressing by the individuals reporting

them. In order to focus the disclosures, we asked participant to disclose experiences of

mistreatment involving someone close to them, with experiences of mistreatment defined

broadly (see "Study 2 – Methods – Materials – Experiences of Mistreatment" for more

information).

Because we observed through Study 1 that many listeners did not respond

supportively to disclosers, and because we know from research that unsupportive

responses to traumatic disclosure predict worse outcomes than nondisclosure, in the

second study we wanted to see whether supportive listening could be taught in a brief

psychoeducational format. The psychoeducational materials were based on results from Study 1 as well as prior research. Examining the effectiveness of this psychoeducational component in teaching and/or enhancing supportive responses may inform or act as a simple and cost-effective way of educating the general public in being supportive following disclosure of difficult experiences.

Summary of Purposes and Goals

In addition to our primary aim of examining the effectiveness of these psychoeducational materials, a second goal was to replicate some of the Study 1 findings regarding posture, interruptions and listeners' negative reactions to disclosure. Third, we attempted to transform the coding scheme from Study 1 into a more relevant and detailed coding scheme in Study 2 and include the assessment of additional concepts that appeared important based on Study 1 (e.g., topic switches, role switches, etc.). Fourth, we wanted to examine a smaller range of disclosure topics (within the broader category of "mistreatment" by someone that the participant trusted, cared for, or depended on), and thus gave participants a more directive set of instructions than in Study 1.

Summary of Hypotheses

In Study 2, we aimed to test the following hypotheses:

1. Listeners in the intervention condition will respond more positively (e.g., lower scores on the USII as rated by disclosers) to the second disclosure than listeners in the control condition, taking into account their responses to the first disclosure.

2. Disclosers in the intervention condition will experience more positive benefits (e.g., increased positive emotion, decreased negative emotion, decreased stress

and arousal) than disclosers in the control condition, taking into account their pre-disclosure levels of each of these variables.

CHAPTER VI

METHOD – STUDY 2

Participants

The sample was comprised of 220 university students and community members. As in Study 1, distinctions were not made between students and community members, precluding the possibility of comparing the demographic characteristics of each group. Recruitment procedures in Study 2 were similar to those implemented in Study 1. For instance, recruitment began with the Department of Psychology's Human Subjects Pool at the University of Oregon. These participants were given academic credit for their participation. In order to participate, each Human Subject Pool participant was required to find a friend, whom he or she had known for at least three months, who would also be willing to participate during the same time. For the majority of the study, this second individual was compensated monetarily if he/she was not eligible for credit. However, once grant funding ran out, if the second individual was not eligible to participate for credit, he/she participated could choose to participate as a volunteer. Approximately 55 pairs of people participated in the study after this change was implemented; there were approximately 11 pairs in which one person participated as a volunteer.

As in Study 1, participants from the Human Subjects Pool did not self-select into the study based on knowledge of the content; rather, participants were selected for the study based on schedule availability and friend availability. In addition, participants with

a history of trauma were not targeted as part of the recruitment process; thus, while over two-thirds of our sample did report a history of trauma (see "Descriptives" section for more details), this was not a requirement for participation in the study. Prior to running the study, approval was granted by the University of Oregon's Institutional Review Board.

Approximately 61% of the participants were female. The gender composition of the pairs of participants was similar to Study 1; in approximately 50% of the pairs both participants were female, in approximately 27% one participant was male and one was female, and in approximately 23% of the pairs both participants were male. Due to random assignment to condition, the gender composition of the dyads were not evenly distributed across conditions. For female-female dyads, 41.8% were in the control group, for female-male dyads, 60% were in the control group, and for male-male dyads, 64% were in the control group. Ages ranged from 18 to 43, (M=19.59, SD=3.26), and the majority identified as European American only (75%). Approximately 92% were born in the United States, and approximately 89% reported that both of their parents were born in the United States. Approximately 95% of the participants reported that their maximum level of education completed was "some college."

Materials

Initial Self-Report Measures

Betrayal Trauma Inventory (BTI)

A shortened version of the BTI (Freyd, DePrince, & Zurbriggen, 2001) was used, but unlike the first study, the CSA supplement was not combined with the BTI (See

Appendix G for a sample page from this measure). Instead of the CSA supplement

following the BTI questions as in study one, participants were asked whether they had

previously disclosed each traumatic experience outside of the survey. If they endorsed

that they had, they were asked the following: "If yes, who was the first person that you

told? (e.g family member, counselor, police, friend, romantic partner);" If yes, how long

after the experience did you *first* disclose that it happened?" (allowed to endorse hours,

days, weeks, months, or years); "If yes, how did this person treat you once you told

him/her what happened?" (allowed to endorse very positively, somewhat positively ,

somewhat negatively, or very negatively).

Relational Health Index-Peer Version (RHI-P)

Psychometric properties of the RHI-P (Liang, Tracy, Taylor, Williams et al.,

2002) are listed in the previous section "Study 1 – Methods – Materials."

Trauma Symptom Checklist (TSC-40)

Psychometric properties of the TSC-40 (Elliott & Briere, 1992) are listed in the

previous section "Study 1 – Materials."

<div align="center">

Initial Open-Ended Questionnaires

</div>

Experiences of Mistreatment

Participants were given the following instructions:

> "Please think of at least two experiences in which you were mistreated or let
> down by someone you trusted, cared for, or depended on. Please think of
> events that you have not told this particular person about before. Or, if you
> have told this person about the events in a general way, at least there should
> be certain important details or aspects of the event you have not previously
> discussed with this friend.
>
> For example, (and these are just examples), you may choose to write about

witnessing someone close to you being severely harmed by someone else, being made to feel unworthy by someone close to you, being made to have sex against your wishes by a trusted other, or even a distressing memory of being left all alone or having your trust betrayed by someone you counted on. After you write them in the space below, please choose two of these, that you would be willing to talk to your partner about. Circle the two on this paper, and write down one each separately on the index cards provided."

Relationship with the Other Participant

Participants were asked the following open-ended questions: 1) For how long have you known your friend? 2) On average, how much time do you spend together each week? 3) In the space below, please describe your relationship with the other participant.

Psychoeducational Materials

These written materials included separate informational handouts for experimental and control participants and separate quizzes for participants in both groups (See appendices H-K). A key for both quizzes was created so that they could be scored on a scale of 0-20 to measure accuracy and to facilitate consistency in scoring. Experimental handouts focused on describing nonverbal and verbal ways of supportively responding to disclosure. Material for this handout was derived from findings from Study 1 as well as prior research, most of which has examined empathic responding in medical contexts (Coulehan et al., 2001; Frankel & Stein, 1999; Pollak et al., 2007; Robertson, 2005; Smith & Hoppe, 1991). Material for the control handout was derived from prior research and other educational materials, most of which was put forth by the Center for Disease Control. This handout focused on three main aspects of living a healthy lifestyle: nutrition (U.S. Department of Health and Human Services and U.S. Department of Agriculture), exercise (US Department of Health and Human Services,

1996) and sleep hygiene (Taheri, 2006; Thorpy & Yager, 2001; Yager & Thorpy, 2001). The two handouts were matched on length (one-page, single-spaced), word count (within one word), level of vocabulary, and structure (parallel sentence structure, same number of sections and points within each section). The two quizzes were matched on length (approximately two-pages, double-spaced), level of vocabulary, and structure (same number of questions, same number of true/false and short-answer questions). Several people other than the principal investigator and faculty advisor reviewed various drafts of these documents to help improve clarity and make the documents as similar as possible across conditions.

Post-Disclosure Questionnaires

Post-Disclosure Questionnaire for Participant A (Discloser) Only

This measure was administered twice (once after each disclosure) and included the following questions: 1) "Have you told this person about this experience before?" (allowed to answer yes or no); 2) "Have you told other people, other than this friend, about this experience before?" (allowed to answer yes or no); 3) "Overall, how would you describe what it was like to talk with your friend about this experience?" (open-ended). Following these questions, the Unsupportive Social Interactions Inventory (USII; Ingram, Betz, Mindes, Schmitt, & Smith, 2001), Positive and Negative Affect – Expanded Version (PANAS-X; PANAS-X; Watson & Clark, 1994), and Stress Arousal Checklist (SACL; Mackay, Cox, Burrows, & Lazzerini, 1978), were administered. These measures are described in more detail below.

Post Disclosure Questionnaire for Participant B (Listener) Only

This measure was administered twice (once after each disclosure) and included the following questions: 1) "Has your friend told you about this experience before?" (allowed to answer yes or no); 2) "Overall, how would you describe what it was like to talk with your friend about this experience?" (open-ended).

Unsupportive Social Interactions Inventory (USII)

The USII (Ingram et al., 2001) is a 24-item measure used to assess unsupportive or upsetting responses given by others regarding a stressful life experience. The measure is comprised of four subscales: distancing (e.g., "did not seem to want to hear about it," "changed the subject before I wanted to," "discouraged me from expressing feelings such as anger, hurt or sadness"), bumbling (e.g, "did not seem to know what to say, or seemed afraid of saying or doing the 'wrong' thing," "from voice tone, expression, or body language, I got the feeling he or she was uncomfortable talking about it,"), minimizing (e.g., "felt that I should stop worrying about the event and just forget about it," "said that I should look on the bright side"), and blaming (e.g., "asked 'why' questions about my role in the event," "seemed disappointed in me," "made 'should' or 'shouldn't have' comments about my role in the event"). For each interaction, the USII was completed by the discloser, listener, and coder. That is, the discloser rated the listener's level of unsupportive behaviors, the listener rated his/her own unsupportive behaviors, and the coder rated the listener's unsupportive behaviors.

Exploratory and confirmatory factor analyses conducted by Ingram et al. (2001) have demonstrated adequate internal consistency reliability for this four-factor structure

(α=.86 for total scale, α ranged from .73 to .85 for each subscale). In those reliability

analyses, each subscale was significantly correlated with the total scale and the other

subscales. Additional analyses conducted by Ingram et al. (2001) have demonstrated a

distinction between the stressor-specific unsupportive social interactions measured by the

USII and general negative social interactions. Furthermore, the positive relationship

between USII scores and symptomatology has been shown to remain after controlling for

trait negative affectivity, suggesting that the USII is not a reflection solely of negative

affect and has predictive power in and of itself. Lastly, the USII has demonstrated strong

predictive validity in terms of predicting failure to disclose (Figueiredo et al., 2004),

psychological (Ingram et al., 2001; Ingram, Jones, Fass, Neidig, & Song, 1999; Mindes,

Ingram, Kliewer, & James, 2003; Smith & Ingram, 2004) and physical symptoms

(Ingram et al., 2001), often beyond the variance predicted by other factors such as

physical functioning, stress, and social support.

Positive and Negative Affect Scale-Expanded Version (PANAS-X)

The PANAS-X (Watson & Clark, 1994) is a 60-item adjective checklist that

respondents rate on a scale from 1 (very slightly/not at all) to 5 (extremely), with two

higher order scales (Positive and Negative Affect). Seven lower order scales regarding

more specific affect have also been constructed (fear, sadness, guilt, hostility, shyness,

fatigue, and surprise). For the purposes of the present study both the discloser and

listener completed the PANAS-X, as a way of assessing their own affective state, before

and after the second disclosure. In data analyses, the higher order scales of positive and

negative affect were utilized.

In prior research on university, community, and clinical samples, internal consistencies for the positive and negative affect scales ranges from .83 to .90 and from .79 to .91 for the two scales, respectively. Strong divergent validity has been demonstrated, as well as strong convergent validity between self and peer ratings and between scores on the PANAS-X and other measures that assess multiple levels of affect (e.g. Profile of Mood States (POMS)) (Watson & Clark, 1994). Its utility for our study is supported by its use as measure of short-term affect. More specifically, prior research has demonstrated strong correlations between the PANAS subscale of sadness and depressive symptom levels as measured by the CES-D and STAI (r=.69 and r=.56, respectively) (Watson & Clark, 1994). In addition, research supports the sensitivity of the PANAS to fluctuations in external and internal circumstances (Watson & Clark, 1994). The PANAS has also been used on adolescent and young adult populations (e.g., Heaven & Ciarrochi, 2007; Hussong & Hicks, 2003), suggesting that it is appropriate for a college sample.

Stress Arousal Checklist (SACL)

The SACL (Mackay, Cox, Burrows, & Lazzerini, 1978) is a 30-item measure used to assess stress and arousal levels using adjectives often associated with descriptions of stressful experiences. For each adjective listed, participants are asked to rate the extent to which they feel each adjective describes their current feelings (allowed to endorse the following: ++ if the word definitely describes feelings, + if the word more or less describes feelings, ? if the person does not know the word or cannot decide whether it describes his/her feelings, or – if the word does not describe the person's feelings.) Prior

factor analyses have been conducted and have identified a two-factor structure: stress and arousal (Fischer & Donatelli, 1987; Mackay et al., 1978). Strong validity has also been demonstrated previously, in that scores have been shown to increase in response to stressors (Burrows, Cox, & Simpson, 1977; King, Burrows, & Stanley, 1983), and scores on the SACL do significantly correlate with other physiological measures of stress (Burrows et al., 1977; Mackay et al., 1978).

Content of Disclosure

For approximately 73% of participants, additional data were collected regarding the participants' prior exposure to material related to listening to people talking about difficult life experiences (e.g., "Some people have received prior education or training about how to listen to and/or communicate with people who are talking about difficult life experiences. Prior to today, what has been your exposure to this kind of information?" rated on a scale ranging from, "I've never before been exposed to this information" to "I have extensive training (examples: crisis line training, took a course)") as well as each participant's perception of the depth of each topic discussed (e.g., "In today's study, how would you rate the FIRST topic you discussed?" rated on a scale ranging from, "It was not a very deep, personal, or important topic to me" to "It was a very deep, personal, or important topic to me"). Other questions related to the chosen topics were also included (e.g, "In today's study, while you were talking about the FIRST topic, how much did you feel you were holding back certain thoughts, emotions, or details?" rated on a scale ranging from, "I was very guarded" to "I was very open" and "If tomorrow you had the opportunity to talk about this FIRST topic with this same

person, how would you respond?" rated on a scale ranging from "I would not want to talk to this person at all" to "I would discuss deeper or more personal information or details.") Because this questionnaire was not included initially, it was added as the last page of the last set of questionnaires each participant completed (the second post-disclosure questionnaire), so that it would not disrupt the data collection process and data from the participants who did and did not complete this questionnaire could reasonably be included together in the same sample.

Coding System

The coding system utilized in Study 1 was revised for use in Study 2. The SRQ (Ullman, 2000) was replaced with the 24-item USII (Ingram et al, 2001), as we thought the USII would be more effective in capturing listeners' responses to the topics disclosed in our study since the USII was designed to assess reactions to a broader range of stressful experiences (e.g., bumbling, distancing, minimizing, and blaming; see "Method - Study 2 – Materials – USII" for more information). The participants also used the USII (Ingram et al., 2001) to rate the listener's responses to the discloser. As in Study 1, the coders also measured posture of both participants at three time points during the interaction (at the beginning, 3 minutes into the conversation, and 6 minutes into the conversation), count nonverbal and verbal interruptions to disclosure, and complete the global assessment (GAC) measure. Additional items that were added included the number of times the topic was switched (i.e., from the initial topic to a different topic) and the number of times the participants switched roles (i.e., the listener became the discloser). A section on listener and discloser facial expressions and tone of voice during

the interaction were also included. These items were derived in large part from the "Nonverbal Evaluation Form for Cooperative Lessons" developed by Sweetland (n.d.), but altered slightly for our purposes (e.g., not all items were used, some wording was changed, a likert scale was added following each item to determine the extent to which the participants' tones and facial expressions had each of the listed characteristics).

In order to attain interrater reliability on this coding system, coders underwent the same training and procedure as in Study 1, and used videotapes from Study 1 during this process. The instructions document was also altered to clarify any issues that arose during the training process. Two undergraduate research assistants were trained in the coding system for research credit; these research assistants were different than those who coded in Study 1. Thirty videos from Study 1 were used by coders to practice using the coding system and achieve interrater reliability. The videos were chosen based on content of the disclosure; since in Study 2 the disclosure was more focused on an experience of mistreatment, we wanted coders to practice coding videos that would be similar in content to the actual videos. Thus, the videos that included disclosures with seemingly less superficial topics, and that lasted longer than 1-2 minutes, were used for the purposes of achieving interrater reliability.

Coders began by watching 5 tapes and rating the interactions with the coding scheme. Coders were instructed to watch the first eight minutes of the video and to rate the "USII" section of the coding system. They then coded both participants' posture at various time points and watched the video a second time to record the number of times the listener interrupted the discloser, the number of times the topic was switched by the

discloser, the number of times the topic was switched by the listener, and the number of times the participants switched roles. The criteria utilized in Study 1 for classifying nonverbal and verbal interruptions were expanded upon for use in Study 2. Following this, coders completed the "global assessment" section and the sections on the listeners' and disclosers' tone of voice and facial expressions. Lastly, coders were asked to record any experiences and impressions they felt were important to note (e.g., what they noticed, what the coding system seemed to be missing/not assessing). Coders then met with the principal investigator for a discussion of all ratings and clarification of specific items.

Each coder then coded 5 more videotapes. The coders met with the principal investigator after each videotape was coded to discuss any ratings that were not within 2 points of one another and to address any difficulties in ratings items on each particular tape. Any items that did not seem to vary across participants, and any biases coders seemed to have in using certain numbers on the rating scales, were discussed.

Before making any changes to the coding system based on the coders' experiences, interrater reliability analyses of these 10 videotapes were conducted. Two items in the USII ("The listener responded to the discloser with uninvited physical touching, such as hugging" and "The listener did something for the discloser that he/she wanted to do and could have done for his/herself, as if he or she thought the discloser was no longer capable") did not have variability across participants or within coders, likely because coders rarely observed any of these behaviors in this context (e.g., in the confined research setting doing something for the discloser that he/she wanted to do is particularly difficult, and perhaps the set-up of the rooms precluded physical touching). These items

were dropped. The coder instructions document was altered to reflect specific clarification of how to rate various items, and certain phrases were added to the items themselves to assist coders in rating them in the moment.

Using the second revision of the coding system, coders rated 20 more videotapes (see Appendix L). Reliability analyses revealed that the trained coders had achieved high interrater reliability on the coding system (USII ICC = .683; for posture, average Kappa = .833; global assessment ICC = .722; interruptions ICC = .865; disclosure topic switches ICC=.809; listener topic switches ICC = .947; role switches ICC = .853; tone ICC = .634; facial expression ICC = .489; all $ps<.05$). Some of these measures, to the best of our knowledge, had never before been used in a coding context or had been validated for their use in coding schemes. The USII, for instance, has only been used in prior research as a self-report measure, and thus there are no data supporting the translation of this self-report measure into a coding tool. The tone and facial expression measure that was created for the use in this study, yet was largely derived from Sweetland's (n.d.) work on evaluating teacher performance, had no been validated psychometrically. Thus, for at least these two measures, there was no prior research supporting their reliability as coding measures; in other words, there was no evidence that other researchers had been able to train coders to be reliable in rating these items. Because of this, and the fact that coders went through several months of training to increase reliability, any items that coders could not rate reliability throughout the course of coding were dropped from the coding system. Other coding measures were created for Study 1 and used again in Study 2 (e.g.,

posture, global assessment, interruptions); the remaining measures were created for Study

2 (e.g., disclosure topic switches; listener topic switches; role switches).

The final coding system included 68 items: 22 USII items, 6 posture items (3 for

the discloser and 3 for the listener rated at the beginning of the disclosure, 3 minutes into

the disclosure, and 6 minutes into the disclosure), items regarding interruptions (1-item),

topic switches (2-items, 1 for those initiated by discloser and one for those initiated by

the listener), and role switches (1-item), the 8-item GAC from Study 1, items assessing

tone of the listener (5-items) and discloser (5-items), and items assessing facial

expressions for listener (9-items) and discloser (9-items) (See Appendix L for Final

Coder Document).

Procedure

The same general experimental procedure used in the first study was used in the

second study. In total, the experiment lasted approximately 90 minutes. Pairs of

participants were randomly assigned to an experimental or control condition by the

principal investigator; research assistants were blind to condition. In the course of the

study, there were only 2 pairs in which the research assistant was made aware of the

condition (typically because participants asked questions during the quiz section of the

study).

As in Study 1, participants completed a series of initial questionnaires after giving

informed consent. During this time, participants were asked to write down on the index

cards two of their experiences of mistreatment by someone that the participant trusted,

cared for, or depended on (see "Study 2 – Methods – Materials – Experiences of

Mistreatment" for more information). To protect their privacy, participants completed all questionnaires in separate rooms and were in the same room only for the disclosure portions of the study. Upon reuniting the pair, the research assistant flipped a coin to determine who would be assigned which role (e.g., discloser or listener) and then shuffled the discloser's two cards to select the first disclosure topic; thus, the order in which the two events were disclosed was presumably random. The discloser (Participant A) was then given the following instructions: "Please talk about the experience on this card. Remember, if you have told your partner about the events in a general way, please tell him/her the important details or aspects of the event you have not previously discussed." To Participant B (the listener), the researcher said, "Your job is to listen to your friend." Research assistants were given an experimenter script as well as a list of scripted responses to possible questions in order to maintain consistency in interacting with the participants.

For Study 2 the length of the disclosure interaction was reduced from 20 minutes to 8 minutes and the instructions for the disclosure slightly modified as mentioned above. Following the disclosure interaction, both participants completed a series of post-disclosure questionnaires. Participants were then given sealed envelopes containing written psychoeducational materials regarding either healthy lifestyle improvements (see Appendix H) or supportive listening techniques (see Appendix I). Both participants in each pair received the same materials. Participants were given 10 minutes to study this material and 5 minutes to take a short quiz on this material (see Appendices J and K). While studying, participants were given an index card on which they could take notes and

to which they could refer during the quiz. After completing the quiz, there was a second

8-minute disclosure in which the discloser was asked to discuss the experience written on

the second index card. This was followed by completion of a second set of post-

disclosure questionnaires and debriefing period.

CHAPTER VII

RESULTS AND DISCUSSION – STUDY 2

Descriptives

The correlations between HiBTs, LoBTs, average responses to first disclosures of HiBTs and LoBTs, average latency to first disclosure of HiBTs and LoBTs, trauma symptoms, relational health, and the length of the relationship between participants, can be found in Table 3.

Approximately 70% of the sample indicated that they experienced at least one type of traumatic event on the BTI, with 42.3% of the sample indicating that they had experienced at least one form of emotional, physical, or sexual abuse. In addition, 32.7% indicated that they experienced at least one type of trauma with high betrayal (high BT) and 22.3% indicated that they experienced at least one type of trauma with low betrayal (low BT). The number of types of HiBTs reported on the BTI was significantly and positively associated with the number of types of LoBTs ($r = .371$, n=220, p<.01, $R^2=.138$). Number of types of both HiBTs ($r = .233$, n=216, p<.01, $R^2=.054$) and LoBTs ($r = .225$, n=216, p<.01, $R^2=.051$) were significantly and positively correlated with trauma symptoms.

Retrospective accounts of responses to the first disclosure of trauma were also examined, even though these traumatic experiences were not necessarily disclosed to the other participant in the context of the study. If a participant endorsed that they had

previously experienced a particular trauma and had also disclosed that experience, the

participants answered questions about the ways in which people responded to the first

disclosure of that experience. An average was calculated separately for HiBTs and

LoBTs to capture an overall level of responses to first disclosures. Participants assessed

these responses on a 4-point Likert scale item that ranged from "very positively" to "very

Table 3
Correlation Table - Study 2 - Descriptives

Variable	1	2	3	4	5	6	7	8	9
1. HiBT[a]	–	.371**	-.128	.096	.033	.062	.233**	.083	-.007
2. LoBT[b]		–	-.181	-.007	-.089	-.141	.225**	.028	-.027
3. Responses HiBT[c]			–	.417*	.242*	.169	-.023	-.022	-.094
4. Responses LoBT[d]				–	.163	.080	-.076	.091	.007
5. Latency HiBT[e]					–	.521**	.040	-.116	-.222
6. Latency LoBT[f]						–	.055	-.168	.076
7. Trauma Symptoms[g]							–	-.124	-.005
8. Relational Health[h]								–	.167*
9. Relational Duration[i]									–

Note. [a]HiBT = number of traumas with high betrayal reported on BTI. [b]LoBT = number of traumas with low betrayal reported on BTI. [c]Responses HiBT = average responses to disclosure of HiBTs (range 1-5). [d]Responses LoBT = average responses to disclosure of LoBTs. [e]Latency HiBT = average latency to first disclosure of HiBTs. [f]Latency LoBT = average latency to first disclosure of LoBTs (range 1-5). [g]Trauma Symptoms = score on TSC-40. [h]Relational Health = score on the RHI-P. [i]Relational Duration = length of relationship with other participant.
*$p < .05$. **$p < .01$.

negatively," with higher scores indicating more negative responses. Similarly, data

regarding the latency from the onset of trauma to first disclosure were also collected and separate averages were calculated for HiBTs and LoBTs. Latency to first disclosure was assessed on a 5-point Likert scale that ranged from "hours" to "years," with higher scores representing longer latencies.

Responses to first disclosures of HiBTs were significantly and positively correlated with first disclosures of LoBTs ($r = .417$, n=28, p<.05, $R^2=.174$). Responses to the first disclosures of HiBTs were significantly and positively correlated with latency of disclosure of HiBTs ($r = .242$, n=71, p<.05, $R^2=.059$), such that more negative responses to first disclosures were associated with longer latencies of disclosure. Since these results are correlational we cannot ascertain the direction of this relationship.

While it is possible that waiting a longer amount of time to disclose HiBTs leads to more negative responses to first disclosures of HiBTs, it is also possible that negative responses impact disclosure. For instance, the BTI assesses number of types of trauma rather than each individual trauma a person has ever experienced. Participants are asked to select the most distressing or significant trauma within that trauma type when answering the specific questions about perpetrator characteristics and disclosure. Therefore, participants could experience multiple instances of sexual abuse, for instance, but would answer disclosure questions related to only one of these experiences. It is possible that not all traumas that individuals experience are disclosed at the same time, and that if negative or even neutral responses are received when some traumas are disclosed, survivors will be more likely to wait longer to disclose other traumas. This hypothesis is supported by the finding that the latency of disclosure for HiBTs was

significantly and positively associated with the latency of disclosure for LoBTs (r = .521, n=28, p<.01, R^2=.271). Of course it is also possible that some survivors may wait to disclose their traumas, regardless of trauma type.

Unlike the findings of Study 1, we did not find that the number of types of HiBTs or LoBTs were associated with negative responses to disclosures of such traumas (ps>.05). However, this could be because of the differences in the measures used in each of the two studies. In Study 1, we used a previously validated measure that assessed several kinds of reactions to traumatic disclosure, whereas in Study 2 we only used 1-item to assess overall levels of responses. Thus, it is possible that by constraining the measure of this construct we decreased the variability.

Higher levels of relational health were significantly and positively associated with relationship length (measured in the amount of years during which the participants reported knowing one another) (r = .167, n=214, p<.05, R^2=.028). Unlike Study 1, we did not find in Study 2 that higher levels of trauma symptoms were associated with lower levels of relational health; however, this association did approach significance, (r = -.124, p>.05).

<div align="center">Exploratory Analyses</div>

<div align="center">*Disclosure Topics – Experiences of Mistreatment*</div>

Categories describing the topics that participants chose to disclose were created. A set of 18 general topics was created and several of these general categories were broken down into more specific categories. In addition to these 18 topics, one additional category was used for topics that either fit into multiple categories or did not fit into any

of the categories created. A list of the various categories is included in Table 4, along with excerpts from participant's responses to illustrate examples of topics that were classified into each category.

The frequency with which participants reported each type of topic is included in Table 5. Topics are listed separately for disclosers and listeners and for the two topics described by each discloser and listener. For disclosers, distinctions are made between the first and second topics disclosed, even though the order of topic disclosure was randomly assigned. Although this distinction (between first and second topic) is also made for listeners, listeners did not disclose the topics they chose to write down, and thus the designation of first and second topics is arbitrary and used solely for the purposes of identifying frequency of topic.

Content/Nature of Disclosure

When asked to rate their level of exposure to information describing how to listen to and/or communicate with people who are talking about difficult life experiences, most disclosers (66.7%) and listeners (63.2%) reported a low to moderate level of exposure (i.e., 1-3 on a 6-point scale). On average, approximately 59.5% of disclosers rated the first topics they disclosed as fairly deep, personal, or important (i.e., 4-6 on a 6-point scale). This figure was slightly higher on the second topic they disclosed, with 74.7% rated as fairly deep, personal, or important (i.e., 4-6 on a 6-point scale). On average, most disclosers reported being moderately to very open in discussing both the first (67.1%) and second (75.9%) topics (i.e., 4-6 on a 6-point scale). Most disclosers also reported a high likelihood of willingness to talk to the same person in greater depth or detail if given the

opportunity for both the first (57%) and second (63.3%) topics (i.e., 4-6 on a 6-point scale).

Since both listeners and disclosers completed questions regarding the content/nature of the disclosed topics, graphs were generated to compare the perceptions of listeners' and disclosers' in both the experimental and control groups (Figure 3). In order to take changes that occurred over time into account, difference scores were calculated (the ratings for the first disclosure were subtracted from the ratings for the second disclosure). Thus, higher difference scores represent greater increases from the first disclosure to the second disclosure.

Although no significant effects were found, several nonsignificant trends were observed. For instance, regarding changes from the first to second disclosure in level of openness and willingness to talk to listeners on another occasion about the topic, listeners seemed to endorse greater levels of change than disclosers; that is, listeners rated disclosers as more open and more willing to talk with them again over time. Disclosers' ratings of themselves on these variables, however, were similar across conditions and over time. In addition, listeners in the experimental condition tended to endorse greater levels of change than listeners in the control condition. While this pattern was observed for both the openness and talk again variables, the opposite pattern was observed for the variable regarding the deepness or importance of the topic. That is, disclosers in the experimental condition endorsed greater increases in deepness of the topic than both disclosers in the control condition and listeners in the experimental group. This finding supports prior research suggesting that disclosing can "increase feelings of vulnerability"

or "increase their salience" (Cutrona, 1986, p. 207). Since the order of the disclosed topics was randomly assigned the likelihood that deeper topics were systematically disclosed second is reduced; furthermore, if this were the case, this association would likely be significant for participants in both the experimental and control groups. However, it is possible that after disclosing one experience disclosers perceived their second topics as deeper, or perhaps the listener's enhanced levels of support allowed them to discuss deeper details than they had previously, making the topic feel more important.

Listeners' Emotional Experiences

An independent samples T-test comparing average difference scores for listeners in the control and experimental groups revealed a significant difference from pre- to post-disclosure on dimensions of positive affect, $t(97)$=-2.228, p<.05 and sadness, $t(97)$=-2.615, p<.05, as measured by the listeners' reports on the PANAS. Listeners in the control condition experienced significantly greater decreases in both positive affect (M=-.2942, SD=.4368) and sadness (M=-.1472, SD=.3355) from pre- to post-disclosure as compared to listeners in the experimental group (M=-.1021, SD=.4188 and M=-.0609, SD=.4539, respectively).

Although these findings are seemingly conflicting, there are several possible explanations. First, it is important to note that the positive affect subscale includes items such as "proud," "attentive," "interested," "alert," "determined," and therefore may measure a construct that is quite different than a traditional conceptualization of positive affect as including feelings of joy or happiness. In addition, the positive affect subscale

is much broader than the sadness subscale and includes many more items (i.e., 10 items vs. 5 items). It is also possible that these seemingly conflicting findings reflect the complexity of hearing about difficult life experiences. In addition, perhaps not having the guidance of the intervention introduced some insecurity in the listeners' abilities to respond to the disclosers, which led to decreased positive affect. Furthermore, perhaps listeners in the control condition, without the help of the intervention, were not as connected to the disclosers, or as able to feel as much empathy for the disclosers' experiences; this disconnection, detachment, or decreased likelihood of relating or understanding, could have allowed for a greater decrease in sadness and positive affect. It is important that these possibilities be examined in future research.

Coders' Ratings of Disclosure – Preliminary Analyses

Because coding of the videos was not yet completed at the time of writing this draft, preliminary correlation analyses were conducted. For each pair included in these preliminary analyses, only one coder had completed the ratings as of the time of writing this draft. Analyses were conducted separately for data from the experimental (n= 41) and control (n=44) groups. Difference scores were calculated for each variable to measure change that occurred from pre- to post-disclosure, and all correlation analyses were conducted using these difference scores.

For the control group, changes on the USII, as rated by coder, were positively and significantly correlated with changes on the USII, as rated by disclosers (r = .468, n=44, $p<.01$), suggesting that coders and disclosers rated the listener's level of unsupportive behaviors similarly. In addition, changes on the USII, as rated by disclosers, were

Table 4

Topic Categories and Examples

Topic	Example
1) Feeling let down	"I had no help doing a project…I felt let down by my group"
2a) Murder	"Sophomore year my friend M. was shot 5 times…"
2b) Death (not suicide/illness)	"Losing my little sister in a car accident on her 14th birthday
3a) Suicide attempt/ideation	"My sister was taken to the hospital for having suicidal thoughts…"
3b) Actual suicide	" My grandfather's suicide …"
3c) Self-harm	"… made to feel inadequate by people very close to me…led me to purge myself on occasion, eat too little, and physically harm myself with a razor blade "
4) Blamed; Felt guilty/unworthy	"My father told me I would fail in college…I depended on him to be supportive …"
5) Teasing; Bullying; Relational Aggression	"When [my best friend] visited she made fun of me a lot and sided with her other best friend while her friend made jokes at my expense."
6) Broken Promises	"My brother went back on his word about taking me to an important event…"

Table 4 (continued).

Topic	Example
7) Distressing memory of being left alone/lost	"When I was five, my mom forgot about me and never came to pick me up from school. Panicked, I walked to a friends house…until she picked me up hours later
8a) Taken advantage of (money)	"When my parents used up my savings account for stock market and lost it"
8b) Taken advantage of (sexually or physically)	"A guy I dated made me feel ugly, unworthy. He was only with me because he wanted to experience sex with a black girl. I lost my virginity to him and I hate it!"
8c) Taken advantage of (generally)	"I was being used by my cousin so she could go and party when I had other things that I needed to do than just please her wants"
9a) Alcoholism	"My mother's alcohol problem. How it is ruining the family"
9b) Other drug use	"My older sister followed in my mother's exact footsteps…she is now addicted to cocaine and [her children] placed in the care and custody of the state…"
10a) Illness	"My grandpa was very sick…he eventually became paralyzed, waist down, and delusional….I never got to say bye…"
10b) Injury	"My best friend's car accident where he ended up in the ICU"

Table 4 (continued).

Topic	Example
11a) Break-ups	"My trust was betrayed by my ex-boyfriend of 2 years…when I decided to move to Oregon we broke up and we haven't talked since"
11b) Divorce	"My parents getting a divorce and all the bad things they tell me about each other. I trust them both, yet feel like I'm getting stuck in the middle"
11c) Cheating	"Dated a girl in high school, first love/first girl I had an intimate relationship with. We dated for almost 2 years…I found out she had cheated on me multiple times…"
12a) Someone not being there when needed	"I was always let down by my mom when me and my dad would get into arguments…she always either remained silent or agreed with my dad"
12b) Someone being chosen over you/getting ditched or stood up	"My older sister says she wants to bond and become friends, so she'll plan days where she and I are supposed to hang out. She ends up ditching me…"
13a) General betrayal	"My best friend A. could never be trusted. I wanted to tell her things that were going on in my life, but I knew if I did everyone would know about it…"

Table 4 (continued).

Topic	Example
13b) Sexual betrayal	"…my best friend/idol slept with my ex-girlfriend shortly after we broke up and I had just told my friend that I realized I loved her…"
13c) Deception/lies	"…my mom had irregular cells in her ovaries that were thought to be cancer-causing…my parents didn't tell me the severity…I felt lied to by my parents"
14a) Secret revealed	"…I told the person I love and trust the most a family secret I had never told anyone. He then told someone else about it when I had asked him not to…"
14b) Rumors	"My teammate made up a rumor that I was sleeping with my track coach"
15) Phys. Abandonment/ Neglect	"Growing up without my dad trying to be in my life"
16a) Experienced phys. abuse or violence	"…my father attempted to kill me. He repeatedly abused me, but this time he left me basically unconscious until the next morning"
16b) Witnessed physical abuse	"Witnessing a female friend being mistreated/abused…Insecure boyfriend accused her of cheating on him and began to grab and throw the young lady…"

Table 4 (continued).

Topic	Example
16c) Knowledge of physical abuse but not witnessed	"My aunt…was physically abused by my uncle. I never saw the abuse happen, I would only see the bruises on her face and legs."
17a) Verbal abuse by family	"…my father verbally attacked me…he called me 'worthless'…"
17b) Verbal abuse by friends/romantic partners	"Being mistreated by an ex-boyfriend emotionally…feeling guilty, unworthy, like a less significant human being because of his actions or things he said"
17c) Witnessed verbal abuse	"Visually witnessing my close friend being emotionally/psychologically abused by her boyfriend. She was pregnant and he would periodically leave/threaten to leave her. Tell her to give the baby up…that he didn't want either one of them"
18a) Sexual pressure	"My boyfriend always wanting to go farther than I was comfortable with (sexually)…"
18b) Sexual abuse	"My mom's friend molested me…and he comes to our house frequently. I get scared when he visits and I am home alone…I am still afraid of him"
18c) Knowledge of sexual abuse	"My sister was raped during her freshman year of high school…"

Table 5
Frequency of Topic Reporting

Topic	Discl1	List1	Discl2	List2
1) Let down	6	7	8	12
2) Death	5	0	3	0
2a) Murder	0	0	1	0
2b) Non-suicide, non-illness	5	0	2	0
3) Suicide/Self-harm	0	7	6	2
3a) Suicide attempt/ideation	0	2	6	1
3b) Actual suicide	0	2	0	1
3c) Self-harm behaviors	0	3	0	0
4) Blamed/felt guilty/unworthy	9	3	3	2
5) Teasing/Bullying/Relational Aggression	4	7	2	1
6) Broken Promises	4	4	3	2
7) Distressing memory of being left alone/lost	2	1	1	6
8) Being taken advantage of	5	3	5	4
8a) financially	2	3	3	1
8b) sexually/physically	0	0	0	2
8c) generally	3	0	2	1
9) Addiction	6	1	5	8
9a) Alcoholism	3	1	3	8
9b) Other drug use	3	0	2	0

Table 5 (continued)

Topic	Discl1	List1	Discl2	List2
10) Illness/Injury	2	1	3	1
10a) Illness	2	1	2	0
10b) Injury	0	0	1	1
11) Romantic relationships	10	21	11	8
11a) Break-ups	3	5	3	1
11b) Divorce	4	7	1	2
11c) Cheating	3	9	7	5
12) Emotional abandoment	12	12	7	8
12a) Someone not being there when needed	10	3	6	4
12b) Someone else being chosen/ getting ditched	2	9	1	4
13) Betrayal of trust	7	14	9	6
13a) General	3	4	4	3
13b) Sexual	2	3	2	3
13c) Deception/lies	2	7	3	0
14) Trusted person revealed secret/spread rumors	3	4	3	4
14a) Secret revealed	2	3	0	1
14b) Rumor	1	1	3	3
15) Physical abandonment/neglect	4	2	5	9

Table 5 (continued)

Topic	Discl1	List1	Discl2	List2
16) Physical abuse	11	7	13	11
16a) Experienced physical abuse	2	2	7	6
16b) Witnessed physical abuse	8	2	5	2
16c) Knowledge of physical abuse	1	3	1	3
17) Verbal abuse	13	5	14	13
17a) Verbal abuse by family	4	3	8	7
17b) Verbal abuse by friends/romantic partners	4	1	5	5
17c) Witnessed verbal abuse	5	1	1	1
18) Sexual abuse	6	1	5	6
18a) Sexual pressure	3	1	1	0
18b) Sexual abuse	3	0	3	3
18c) Knowledge of sexual abuse	0	0	1	3
19) Multiple topics/miscellaneous	13	10	2	4

Note. Discl1 = discloser's first topic; Discl2 = discloser's second topic; List1 = one topic listed by listener; List2 = other topic listed by listener.
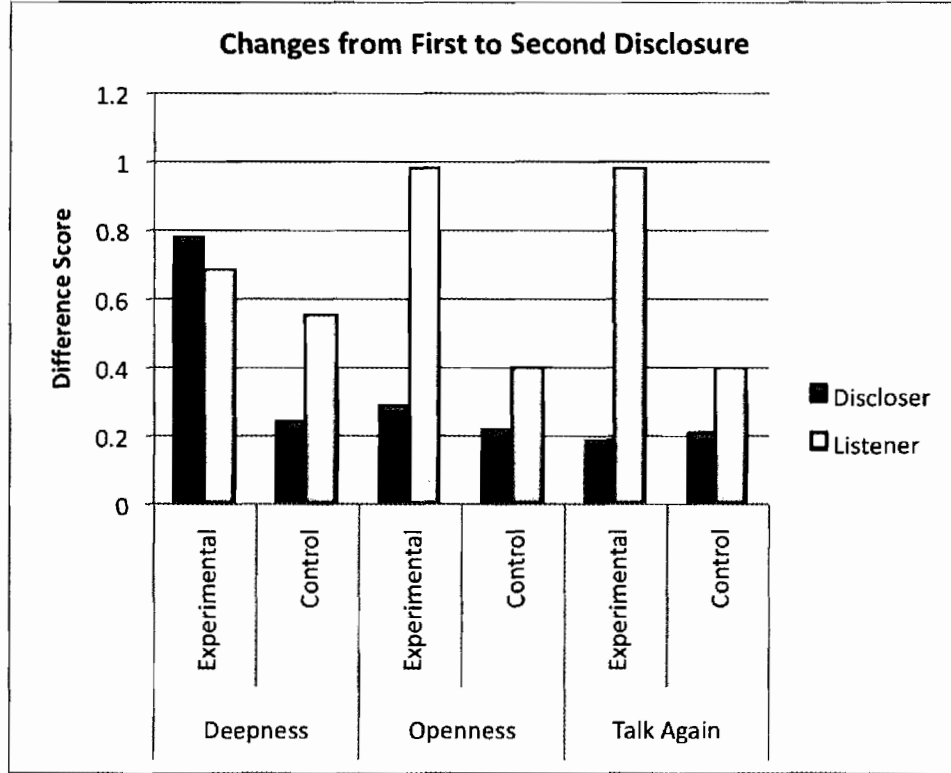
Figure 3. Changes from first to second disclosure as rated by listeners and disclosers in both experimental (n=34) and control (n=41) conditions.

positively and significantly correlated with changes on the USII as rated by listeners (r = .321, n=44, *p*<.05), suggesting similar ratings between disclosers and listeners. None of these correlations were significant for the experimental group, *ps*>.05.

For both the control and experimental groups, changes in the coders' USII ratings from pre- to post-disclosure were positively and significantly correlated with changes on the GAC ratings (for the control group, r = .611, n=44, *p*<.01; for the experimental group, r = .759, n=41, *p*<.01), suggesting that these measures were assessing similar constructs. In both the control and experimental group, decreases in unsupportive behavior assessed by the GAC were associated with fewer topic switches initiated by the listener (r = .380,

n=44, p<.05 and r = .413, n=41, p<.01, respectively) and more listener facial expressions

that conveyed acceptance (r = -.631, n=44, p<.01 and r = -.606, n=41, p<.01,

respectively) and alertness (r = -.603, n=44, p<.01 and r = -.556, n=41, p<.01,

respectively). The association between fewer topic switches initiated by the listener and

decreases on the GAC suggests that coders take the extent to which listeners switch

topics into account when rating unsupportive behaviors, and perhaps view topic

switching as unsupportive.

Although many of the associations between changes in the GAC ratings and

changes in other variables, as measured by correlations between difference scores on

these dimensions, were similar in both the experimental and control,groups, different

patterns emerged. In the control group, for instance, difference scores on the GAC were

positively associated with difference scores for listeners' tone (e.g., faltering) and

negatively associated with difference scores for certain facial expressions (e.g., sadness).

More specifically, decreases in unsupportive behaviors were associated with less of a

faltering tone (r = .320, n=44, p<.05) and more frequent facial expressions of sadness (r =

-.348, n=44, p<.05). Perhaps listeners in the control condition who decreased their

unsupportive behaviors were able to convey more support by speaking in a more

confident tone and expressing empathy by making more sad facial expressions.

In the experimental group, difference scores on the GAC were negatively

associated with variation in the listeners' tone (r = -.508, n=41, p<.01) and positively

associated with difference scores for topic switches initiated by the discloser (r = .412,

n=41, p<.01), such that decreases in unsupportive behavior were associated with

increased variation in the listeners' tone and fewer topic switches initiated by the

discloser. In this group, listeners' who decreased in unsupportive behaviors may have

demonstrated more engagement by using a more varied tone. Further, their behaviors

may have affected the disclosers insofar as disclosers did not switch topics as frequently

(perhaps because they felt more comfortable or heard or understood). Since the coders

were blind to condition, these results might suggest that for those listeners whose

unsupportive behaviors decreased from pre- to post-disclosure, the way in which this

change occurred varied as a function of condition, generating different associations

between variables in each group.

In both the control and experimental groups, increases in interruptions were

significantly associated with decreases in topic switching initiated by the discloser ($r =$

$-.322$, n=44, $p<.05$ and $r = -.333$, n=41, $p<.05$, respectively). Perhaps when listeners

interrupt more, they are interrupting in a way that conveys engagement or facilitates

further disclosure, which leaves the discloser less room to switch topics. Decreases in

topic switches initiated by the listener were significantly correlated with decreases in

topic switches initiated by the discloser (for the control group, $r = .400$, n=44, $p<.01$; for

the experimental group, $r = .474$, n=41, $p<.01$). This suggests that there could be a

dynamic interaction between the participants such that one person's frequency of topic

switching may impact the other participant's. This is similar to the concept of "mutual

influence" that can occur in a dyad (Kenny, Kashy, & Cook, 2006, p. 5). That is, if one

person decreases in topic switching, the other person might "match" this and also

decrease the frequency of this behavior. In the control group only, decreases in topic

switches initiated by the listener were also associated with decreases in role switches ($r =$ .468, n=44, $p<.01$).

Preliminary descriptive analyses of participants' posture revealed that most people (approximately 71% or more) were in an upright position at all three time points of the disclosure. Changes in the frequency of each posture position did not seem very large, nor did the degree of change seem to differ in the experimental group as compared to the control group.

Tests of Hypotheses

Given issues of dependency in analyzing dyadic data, the dyad, rather than each individual person, was treated as the unit of analysis. In following the recommendations put forth by Kenny et al. (2006), the standard dyadic design and data structure were utilized. Although participants rated their own levels of mood and stress/arousal, both participants rated the listeners' level of unsupportive behaviors. If any participant had missing data on the dependent variable being analyzed, the entire pair was excluded from that particular analysis.

In order to examine the effect of the gender composition of the dyad on each dependent variable (USII, PANAS – positive affect subscale [PA], PANAS – negative affect subscale [NA], SACL – stress subscale [SACL-S], and SACL – arousal subscale [SACL-A]), five 3 x 2 Univariate Analyses of Variance were conducted. In each analysis, the between-subjects factors were gender composition of the dyad (female-female, male-female, and male-male) and condition (experimental and control). Pre-disclosure scores were entered as covariates. There were no significant effects of gender,

and no significant interactions between gender and condition, all *ps*>.05. Because there were no significant gender effects, all dyads were used in each analysis, and no further examinations of gender were conducted.

Hypothesis 1

In order to test the prediction that listeners in the experimental condition would respond more positively (e.g., lower scores on the USII as rated by disclosers) during the second disclosure than listeners in the control condition, taking into account their responses to the first disclosure, a regression analysis was conducted. Disclosers' ratings of listeners, rather than listeners' ratings of themselves, were included in analyses.

Post-disclosure USII score as rated by disclosers was the dependent variable. In the first model, group (experimental or control) and centered pre-disclosure USII scores as rated by the discloser were entered as predictors. The second model tested for the additional variance in post-disclosure USII scores accounted for by the interaction between group and pre-disclosure scores; overall the second model accounted for approximately 56% of the variance in post-disclosure USII scores (Adjusted R^2=. 562). The inclusion of the interaction term in the second model resulted in an additional explanation of 6.8% of the variance (R^2 change=.068; $F(1,105)$=16.844, p<.01) (See Table 4). In this second and final model, condition, pre-disclosure USII scores, and the interaction between condition and pre-disclosure USII scores were all significant predictors, *ps*<.05.

In order to clarify the nature of the interaction, graphs were created using estimated values according to the recommendations of Judd, McClelland, & Ryan (2009)

(see Figure 4). For people with low pre-disclosure USII scores (i.e., those people who started off with a low level of unsupportive behaviors), the intervention did not make much of a difference. However, for those people with high pre-disclosure scores (i.e., those people who started off with a high level of unsupportive behaviors), being in the experimental condition was on average associated with lower post-disclosure USII scores compared to the control condition. In other words, the intervention was most effective in decreasing unsupportive behaviors in the group of people with high pre-disclosure levels of unsupportive behaviors. People who are already able (naturally or otherwise) to respond supportively, and do not exhibit as many unsupportive behaviors, may not benefit as much from a basic set of psychoeducational materials like those in the present study, and may benefit more from a more nuanced or detailed set of materials; in other

Table 6
Summary of Hierarchical Regression Analysis for Variables Predicting Listeners' Post-disclosure USII Scores (n=109)

Variable	B	$SE\ B$	β
Step 1			
Condition[a]	-.067	.032	-.144*
Pre-disclosure USII[b]	.729	.074	.677**
Step 2			
Condition	-.076	.030	-.165*
Pre-disclosure USII	.900	.081	.836**
Interaction[c]	-.642	.156	-.308*

Note. $R^2 = .506$ for Step 1; $\Delta R^2 = .068$ for Step 2 *(ps<.01)*.
[a]Condition = experimental or control. [b]Covariate = listeners pre-disclosure score on USII centered around the mean. [c]Interaction between condition and covariate .
*$p < .05$. **$p < .01$.

words, there might be some sort of floor effect in which people who have low scores on this measure do not have much room for improvement (e.g., they cannot score less than a zero on this measure).
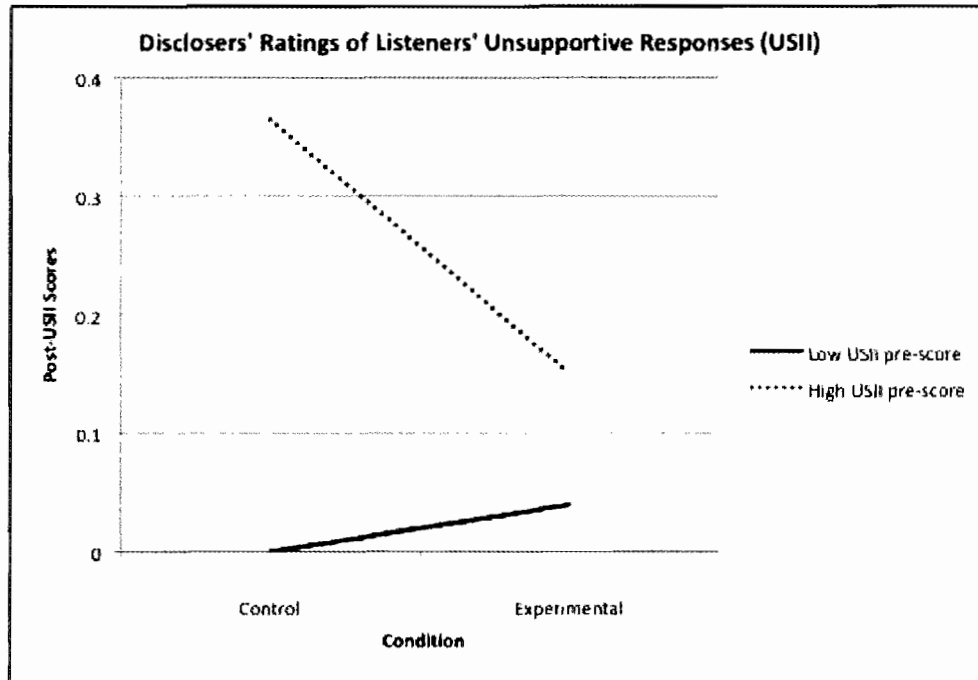

Figure 4. Listeners' post-disclosure USII scores accounting for pre-disclosure scores for both experimental ($n = 53$) and control ($n = 56$) conditions.

Hypothesis 2

In order to test the hypothesis that disclosers in the intervention condition would experience more positive benefits (e.g., increased positive emotion, decreased negative emotion, decreased stress and arousal) than disclosers in the control condition, taking into account their pre-disclosure levels of each of these variables, four regression analyses were conducted.

In order to examine the effect of condition on changes in affect, regression analyses were conducted separately for positive (PA) and negative affect (NA). For the PA analysis, disclosers' post-disclosure PA scores was the dependent variable and group (experimental or control) and disclosers' centered pre-disclosure PA scores were predictors. This model was significant, $F(2,97)=69.05$, $p<.01$. Pre-disclosure PA score was the only significant predictor of post-disclosure PA score. This indicated that people with higher PA before the disclosure had significantly higher levels of PA following the disclosure. A similar pattern of results was found for NA. In this analysis, disclosers' post-disclosure NA scores was the dependent variable and group (experimental or control) and disclosers' centered pre-disclosure NA scores were predictors. This model was significant, $F(2,97)=49.47$, $p<.01$. Pre-disclosure NA score was the only significant predictor of post-disclosure NA score. This indicated that people with higher NA before the disclosure had significantly higher levels of NA following the disclosure.

In the second set of regression analyses, separate analyses were conducted to examine disclosers' level of stress (SACL-S) and arousal (SACL-A), as rated by the stress arousal checklist (SACL). For the regression analysis examining SACL-S, disclosers' post-disclosure SACL-S score was the dependent variable and group (experimental or control) and disclosers' centered pre-disclosure SACL-S were predictors. This model was significant, $F(2,100)=48.71$, $p<.01$. The only significant predictor was pre-disclosure SACL-S score; disclosers who had higher levels of stress before the disclosure had significantly higher levels of stress following the disclosure. For the regression analysis examining SACL-A, a similar pattern of results was observed.

Disclosers' post-disclosure SACL-A score was the dependent variable and group (experimental or control) and disclosers' centered pre-disclosure SACL-A were predictors. This model was significant, $F(2,101)=49.98$, $p<.01$, with the only pre-disclosure SACL-A as the only significant predictor. Disclosers who had higher levels of arousal before the disclosure had significantly higher levels of arousal following the disclosure.

Although these findings might suggest that changes (or lack thereof) in listeners' levels of unsupportive behaviors may not impact mood or stress level, it is also possible that the changes occurred in a more nuanced or subtle way that these measures were not sensitive enough to detect. In addition, it is possible that the kinds of benefits that the disclosers experienced were not related to mood or stress. For instance, when a listener responds supportively to a discloser, that discloser might feel closer or more connected to the listener, more understood, or more able to make sense of the experience. Such benefits may not be related to changes in mood or stress level, but rather are more appropriately captured by other constructs that were not measured in the current study. According to Birrell and Freyd (2006), it is possible that healing does not involve removing someone's pain, even though this is a common way of conceptualizing or measuring healing. That is, it is possible that the healing effects of being listened to do not necessarily involve reducing or eliminating an individual's pain, particularly in the short run.

CHAPTER VIII

GENERAL DISCUSSION

Summary of Findings

We utilized two studies to examine real disclosures in the context of real relationships, in real time. In this way, we attempted to eliminate some of the methodological confounds associated with past research including retrospective report bias and the possible artificiality of disclosure to researchers. We also integrated the perceptions of both members of the dyad, as well as coders, in order to highlight the perception of the discloser, formulate a conceptualization of supportive responses to disclosure, and find ways of assessing changes in level of supportive listening provided that may occur following psychoeducation.

Both verbal and nonverbal constituents of supportive behaviors were examined in Study 1. We sought to identify specific elements of supportive behaviors that were modifiable. We found that listeners who were leaning backward tended to interrupt the discloser significantly more frequently than listeners in neutral positions; we also found that leaning backward was associated with significantly more negative responses to disclosure (as rated by coders). Though not statistically significant, a similar pattern was found when disclosers rated listeners' responses. Since leaning backward was associated both with more negative responses to disclosure and more interruptions, it is possible that being in a backward position reflects a certain listening style that was not viewed very

supportively. It is also possible that listeners who are not being supportive choose to sit in this position, which conveys a certain level of disengagement.

Nonverbal behavior is central to conveying empathy; in fact, prior research indicates that 45% of the variance in empathy is accounted for by nonverbal behavior, while 22% is accounted for by verbal behavior, and 33% by the interaction between verbal and nonverbal behavior (Haase & Tepper, 1972). This research also indicates that engaging in behaviors in one modality (e.g., verbal vs. nonverbal) that are low in empathy can nullify the effects of behaviors in the other modality that are high in empathy. Conversely, a person can engage in behaviors high in empathy as a way of counteracting the effects of low empathy behaviors. It is important to note, however, that there are some exceptions. For instance, while certain nonverbal behaviors (e.g., forward trunk lean and maintenance of eye contact) may facilitate the expression of empathy, if something is said that demonstrates a very low level of empathy, these nonverbal behaviors may not be enough to compensate for the harmful verbal messages. These findings suggest that while "mistakes" can be made and possibly repaired, it is also important for listeners to not become lackadaisical in responding and assume that unhelpful behaviors can be balanced by more helpful ones, since this is not always the case.

In Study 1 we also discovered a quadratic relationship between interruptions and coders' ratings of listeners' negative responses to disclosure. More specifically, moderate levels of interruption were associated with more positive responses. Interestingly, a different pattern, though nonsignificant, emerged when disclosers rated listeners'

behaviors. Given this finding, it is important that future research continues to incorporate the perception of disclosers in defining what is supportive. In fact, it is quite possible for listeners to have helpful intentions, but for these attempts to be perceived as negative or harmful by disclosers (Campbell et al., 2001). One situation in which this may be particularly relevant is the use of self-disclosure as a form of helping. Research examining peer support for breast cancer survivors, for instance, suggests that the context in which self-disclosure occurs impacts the perception of the disclosure (Pistrang, Solomons, & Barker, 1999). While self-disclosure is typically perceived as helpful only if it occurs in the context of high empathy, self-disclosure in and of itself is not sufficient for people to perceive support. That is, even when empathy is high, higher levels of self-disclosure are not necessarily perceived more positively than lower levels of self-disclosure. In addition, the way in which a person self-discloses is important; it is possible for some forms of self-disclosure to be viewed as a way of conveying empathy, whereas other forms may suggest a lack of empathy or even hinder communication. These findings underscore the importance of acknowledging individual differences in perceptions of helping behavior (e.g., some people prefer higher levels of self-disclosure while others prefer lower levels) and of taking overall context of support and self-disclosure into account.

In summary, findings from the current studies and prior research suggest that what listeners believe is helpful may not correspond to disclosers' experiences of support. Therefore, it is possible that the opinion of the discloser is more predictive of later adjustment than the opinion of others. The possible discrepancies between listeners' and

disclosers' perceptions of support underscore the importance of emphasizing the disclosers' perspectives in future research and not relying solely on assumptions about what is helpful and/or the perception of others.

In Study 2, we examined the effectiveness of a brief psychoeducational component in enhancing supportive responses to disclosure. As in Study 1, we studied real disclosures in the context of real relationships, in real time, in order to increase ecological validity and reduce retrospective report bias. One advantage to the implementation of the experimental design was the ability to control for changes that might occur naturally over time (e.g., from the first to second disclosure) due to factors such as learning or increased level of comfort. In addition, we wanted to control for general effects that could be attributable to the receipt of a set of psychoeducational materials.

Our results indicated that people in the experimental condition, compared to those in the control condition, demonstrated a significantly greater decrease in unsupportive behaviors (according to the perspective of the discloser) following receipt of the psychoeducational materials, taking predisclosure levels of unsupportive behaviors into account. Given the research mentioned above regarding the importance of accessing the disclosers' perspectives, the fact that the *disclosers* observed and reported significant improvements in the support the listeners provided makes these findings particularly exciting.

In addition, we found that those participants who started off with high levels of unsupportive behaviors benefitted the most from these materials. Since these materials

were designed as an introduction to techniques that could increase supportive behaviors, this finding makes sense. That is, people who do not start off responding supportively to disclosure may have more to learn or to change about their behaviors, and therefore may find these materials more useful; on the other hand, people who initially responded more supportively may still benefit from a basic introduction, but not benefit as much. Instead, such individuals may gain more from a more in-depth psychoeducational experience.

Limitations

While the current set of studies provides a valuable foundation for future research, particularly given the lack of research in this area, several limitations are of note. First, certain demographic characteristics of the sample may limit generalizability to other groups. For instance, the sample was comprised mostly of pairs of female college students who were friends, around the age of 20, making it difficult to examine the ways in which disclosure processes and responses to disclosure may vary as a function of gender, age, socioeconomic status, and relationship types (e.g., friendships, romantic relationships). In fact, the associations among and interactions between disclosure and various demographic variables (e.g., gender, socioeconomic status, ethnicity) have been shown to be quite complex (Consedine, Sabag-Cohen, & Krivoshekova, 2007).

Prior research has demonstrated that gender, in and of itself, may not predict depth of self-disclosure (e.g., Consedine et al., 2007; Dindia et al., 1997; Dindia & Allen, 1992; Parker & Parrott, 1995), but rather its interaction with other factors may influence self-disclosure. For instance, gender may interact with relationship type such that females may self-disclose to a greater extent in the context of more intimate relationships

(e.g., romantic relationships, female friendships, female family members), whereas men may self-disclose to a greater extent in the context of less intimate relationships (e.g., acquaintances, coworkers) (Consedine et al., 2007). It is also possible that these dynamics can change as a function of the type of experience (e.g., trauma, relationships issues) that is being disclosed (Consedine et al., 2007). Although the wide variety of topics disclosed in the present studies may increase the generalizability of our results, we are also not able to examine differences that may occur as a function of the type of topic disclosed. In addition, while we did examine the impact of gender composition of the dyad on each dependent variable and did not find any significant effects of gender, or any significant interactions between gender and condition, the sample sizes for each of the types of dyads were quite different, such that most dyads were female-female. Thus, it is important that gender differences be examined in future research to clarify whether the lack of gender differences in the current study was due to a lack of power. It is also possible that gender composition of the dyad could be confounded with relationship type such that same-gender dyads were more likely to be friends, while different-gender dyads were more likely to be romantic relationships. Thus, it important that these comparisons and distinctions are made in future research.

Some research has also examined patterns of self-disclosure that may vary as a function of age (e.g., young-adult, middle-aged, elderly) and relationship type (e.g., friendships, family) (Parker & Parrott, 1995). Results indicated that young adults self-disclose for social validation, self-expression, and self-clarification purposes more frequently to friends than family; of these three age groups, only young adults sought

self-clarification via self-disclosure more frequently with friends than family. Middle-aged people disclosed to friends more than family for the purposes of social validation, but disclosed to friends and family equally for self-expression, self-clarification, and social control. Elderly people, on the other hand, disclosed more frequently to family than friends for the purposes of self-expression and social validation; furthermore, only elderly people sought social control via self-disclosure with family more than friends. These findings illustrate that the functions of self-disclosure may change over time, as a function of developmental stage or life circumstances. It is also possible that changes in social networks may also dictate disclosure-related decisions (Parker & Parrott, 1995). Thus, it is important that the present findings are interpreted within context; that is, it is possible that the disclosure processes and supportive behaviors we observed are strongly associated with the demographics of our sample and that not all of the findings would remain if a sample with different demographics was examined.

The majority of the participants in our sample identified as European Americans who were born in the United States and who had parents who were also born in the United States. With such a ethnically and culturally homogenous sample, it is difficult to gain understanding of the ways in which such factors influence the conceptualization of disclosure, the perceived utility of disclosure, barriers and facilitators to disclosure, and responses to disclosure. Thus, it is possible that the findings in the current study represent what young European Americans who were born in the United States view as supportive, and do not define responses to disclosure that would be considered effective across various cultural and ethnic groups.

Although there are likely individual differences in what is considered supportive to whom, the possibility exists that there are also broader cultural variations in what is considered supportive. In light of these possibilities, several researchers have proposed culturally contextualized models of the disclosure of trauma in particular (e.g., Fontes, 1993; Sorsoli, 2007; Tyagi, 2002). Tyagi (2002), for instance, in an attempt to expand on a multilevel framework previously proposed by Obikeze in 1986, discusses individual, community-in-context, cultural, and global levels of traumatic disclosure. The level of analysis in the present study emphasized the individual level, and to some extent the dyadic level as well; although the study of both the individual and the dyad allowed us to take a more ecological approach than if the individual were studied in isolation, the impact of other levels was not assessed. Nonetheless, our more "micro" approach may serve as a foundation for more "macro" approaches in future research.

Another limitation of these studies involves the lack of long-term follow-up. While the findings are promising indications that changes in supportive behaviors can occur through the use of a short psychoeducational component, it is unknown whether these changes are sustainable over time. It is also unclear the extent to which these changes (or lack thereof) may affect the relationship between participants over time. In future research, it would be helpful to know if participants are able to extend what they learn not only to future interactions with that particular participant, but also to other relationships as well.

Inclusion of long-term follow-up would also allow researchers to examine the extent to which participants' expectations of responses to disclosure change over time;

for instance, perhaps disclosers are satisfied with the type and amount of support they receive prior to psychoeducation, but following receipt of these materials change their views about what kinds of support they find helpful and want from others. If disclosers increased their standards for the kinds of responses they deem as supportive following receipt of these psychoeducational materials, we might expect disclosers in the intervention condition to rate listeners more negatively in terms of the support they provided than disclosers in the control condition. If, on the other hand, disclosers lowered their standards for supportive responding, we might expect findings in the opposite direction. Thus, it is possible that expectations of supportive responses and the ways in which they change over time, could impact the both the listeners' and disclosers' perceptions of the listeners' behaviors. Without assessing such expectations directly, however, it is difficult to identify the extent to which they may play a role.

Another issue that has been raised in prior research is that of socially desirable responses as they relate to skill building and training (Lawson & Winkelman, 2003). Although we did not include an item to assess for socially desirable responding in our studies, by relying on multiple raters (e.g., disclosers, listeners, and coders), perhaps the likelihood that effects are solely attributable to socially desirable responses (e.g., a high endorsement of supportive listening behaviors following psychoeducation) is reduced. While socially desirable responding may impact listeners' *ratings* of behaviors, it is also true that it could impact their actual behaviors. That is, when presented with a psychoeducational opportunity, people could feel more motivated to master these skills (Lawson & Winkelman, 2003). It is unclear, however, whether this would actually have

a negative impact on the discloser. If the efforts to improve one's behaviors are genuine and result in a beneficial outcome for disclosers, it is possible that the reasons for wanting to improve (e.g., a desire to be a better friend, a motivation to demonstrate skills that are viewed as socially desirable) are inconsequential. Of course it is possible that certain motivations and intentions may predict longer-lasting changes in behavior than others, but this is a possibility that could be examined in future research.

Through this research we are unable to determine the "active" ingredients of these materials. In other words, it is possible that rather than informing specific behaviors, the materials acted as a means of raising general awareness of the importance of listening and being supportive. Future research could deconstruct these materials and identify elements that are the most useful, so that such elements could be elaborated upon and/or emphasized in future educational materials.

<center>Implications</center>

The findings in the current set of studies have many important implications for future research. First, research regarding ways of educating the general public in responding supportively to the disclosure of stressful life experiences is extremely limited despite the potential benefits that could result. That is, the lack of research is not a reflection of the importance or need for this kind of research. Thus, these findings may serve as beginning steps for continued research in this area.

Stressful life experiences, including experiences regarded as traumatic, are quite common in the general population. In the present studies, 65-70% of participants reported experiencing at least one traumatic event; such high reports of these kinds of incidents

have been reported in other studies as well. In a longitudinal study conducted by Lantz et al. (2005), for instance, 61% of the sample had at least one of the four events surveyed (death of a spouse, divorce, death of a child, and physical assault). It is important to note that these percentages do not include events that occurred but were not reported, as well as other events that may have been experienced as traumatic or stressful but were not surveyed. In other words, these percentages likely reflect underestimates of the sample's exposure to stressful life experiences. Thus, when stressful life experiences are considered more broadly (e.g., financial crises, relationship conflicts, discrimination, health diagnoses), it is likely that an even larger percentage of the population is affected.

When people encounter stressful life experiences, a common response involves the desire to tell others about these experiences. Individuals' intentions in disclosing vary, but may include expressing themselves, clarifying needs, making sense of a situation, seeking validation or support, or gaining some kind of information or tangible support (Ahrens et al., 2007; Parker & Parrott, 1995). In American culture, disclosure is often viewed as a healthy, adaptive, and socially accepted form of coping (Rime, 1995). However, there are also cultural ideas about personal boundaries and individualism that may influence perceptions of when disclosing is "too much" both in terms of amount of detail and types of events that are shared. Such perceptions may also depend on the context (e.g., nature of event being disclosed, type of relationship) and individual difference factors (e.g., disclosure preferences, personality traits). In addition, there are settings in which disclosure may be promoted more than others (e.g., therapeutic relationships, close friendships).

Despite possible social constraints on disclosure, research demonstrates that disclosure can be helpful for a variety of reasons (e.g., Hemenover, 2003; Lepore et al., 2000), but particularly for recovery and adjustment from difficult life events (e.g., Coker et al., 2002). Importantly, responses to disclosure have a strong impact on our adjustment, suggesting that it is not the act of disclosure in and of itself that is most helpful for recovery (e.g., Ahrens et al., 2007; Coker et al., 2002; Figueiredo et al., 2004; Lepore et al., 1996). In fact in some instances, if people do not respond supportively, the effects are worse than if the information is not shared (Figueiredo et al., 2004; Lepore et al., 1996). While disclosing in even everyday circumstances involves risk, the anticipation of unsupportive and harmful responses may act as an additional barrier to disclosure (Ahrens, 2006).

Research also indicates that friends and family members are often chosen as first recipients for traumatic disclosure (e.g., Coker et al., 2002; Fisher, Daigle, Cullen, & Turner, 2003; Paine & Hansen, 2002; Ullman & Filipas, 2001). Yet, many people have not received education or training in responding supportively to disclosure, and are not naturally able to provide support in a helpful way. In fact, approximately two-thirds of participants in the present study reported only low to moderate levels of prior exposure to this kind of information, further emphasizing the importance of education in this area. It is quite possible that people have the desire and motivation to be helpful, but do not know how to be. In addition, it is possible for people to think they are being helpful, but for their responses not to be perceived as such. This has even been shown to be the case for oncologists, where greater confidence in their abilities to be empathic does not translate

into greater empathic responding as rated by patients (Pollak et al., 2007). Thus, it is important to find ways to educate people about supportive responses to disclosure so that they are not relying on what they assume is helpful. Moreover, recommendations for enhancing supportive responses may not be useful if they are not informed by research regarding constituents of supportive responses and effective ways of teaching people about these responses.

In summary, prior research indicates that 1) stressful experiences are common; 2) adjustment to stressful experiences often involves disclosure; 3) the impact of negative responses to disclosure can be more harmful than the effects of nondisclosure; 4) friends and family are often the first to hear about stressful experiences; and 5) research regarding constituents of supportive responses and ways of educating the general public to be supportive is limited.

Since our findings indicate that these psychoeducational materials are capable of decreasing unsupportive behaviors, these materials could be used as a starting point for teaching people in the general public about supportive responses. Although other materials like this may exist in the community (e.g., New Jersey Self-Help Group Clearinghouse, n.d.), those developed for the purposes of the current studies have several advantages. One advantage to these materials is that they have been informed by disclosers' perceptions about what constitutes a supportive response, keeping prior research in mind. In addition, our materials have garnered empirical support regarding their effectiveness. The materials are also relatively short in length and could be administered in a brief format. The fact that the materials are written and do not require

professional expertise for administration also makes them cost-efficient and increases flexibility in the kinds of situations in which they could be administered.

While it is possible that more in-depth didactic trainings regarding supportive responses could be useful, there is also value in finding less-intensive forms of education that are capable of producing meaningful changes, particularly if those changes are observed by disclosers. One context in which these materials could be delivered is in a school setting. Many schools currently offer curricula that devote discussions to healthy relationships as a means of aiding relationship development and preventing violence in relationships. These materials would fit in well during this kind of lesson, as understanding ways of conveying support in the context of relationships is a useful relationship and communication skill. Such skills can be helpful in creating deeper, more connected, and stronger relationships with others and may allow greater trust to be developed (Fogarty et al., 1999). In addition, these techniques may be applicable to listening and responding in a variety of relationships in person, social, and professional contexts.

When others are able to respond more supportively to disclosure, this can increase disclosers' well-being (Fogarty et al., 1999) and sense of validation, decrease feelings of depression and anxiety, and encourage further expression of other emotions (Pollak et al., 2007). While it does take energy and time to be compassionate, covey support, and listen well, it is also very important. The wider distribution of these materials could not only provide guidance that make the task seem more attainable and help address assumptions about what is helpful, but also may increase people's sense of self-efficacy in responding

to others and in turn facilitate the creation of a supportive environment in which to disclose.

APPENDIX A

DEMOGRAPHICS QUESTIONNAIRE – STUDY 1

Demographic Information

1. Your Age _____

2. Your Gender _____

3. Ethnic identification (Please check as many as apply to you):

      a. African American/Black
      b. Hispanic or Latino/a
      c. Native American/American Indian
      d. White/Caucasian/European American
      e. Asian American
      f. Pacific Islander
      g. Other (please specify): _____

4. Where were you born?
      a. United States
      b. Other (please specify): _____

5. Where were your parents/caregivers born?
      a. United States
      b. Other (please specify): _____

6. Are you fluent in spoken English?   Yes ☐   No ☐

7. Do you have a disability? Yes (Please specify) _____   No

8. What is the highest level of education you have completed? _____

9. Number of hours of sleep you got last night: _____

10. How worried/anxious/stressed are you today about life events (for example, school, work, finances, friends, family, etc.)?

      ☐ not at all
      ☐ slightly
      ☐ an average month
      ☐ more than average
      ☐ extremely

11. How would you describe your general mood today?

    ☐ great   ☐ good   ☐ average   ☐ poor   ☐ horrible

APPENDIX B

BETRAYAL TRAUMA INVENTORY & CSA SUPPLEMENT – STUDY 1

Before the age of 18, how often did each of the following events happen to you?

1.	Been in a major earthquake, fire, flood, hurricane, or tornado that resulted in significant loss of personal property, serious injury to yourself or a significant other, the death of a significant other, or the fear of your own death	Never	1-2 Times	More than 2 times
2.	Been in a major automobile, boat, motorcycle, plane, train, or industrial accident that resulted in significant loss of personal property, serious injury to yourself or a significant other, the death of a significant other, or the fear of your own death	Never	1-2 Times	More than 2 times
3.	Witnessed someone with whom <u>you were very close</u> (such as a parent, sibling, caregiver, or intimate partner) committing suicide, being killed, or being injured by another person so severely as to result in marks, bruises, burns, blood, or broken bones. This might include a close friend in combat.	Never	1-2 Times	More than 2 times
4.	Witnessed someone with whom you were <u>not</u> so close undergoing a similar kind of traumatic event.	Never	1-2 Times	More than 2 times
5.	Witnessed someone with whom <u>you were very close</u> deliberately attack one or more of your family member's so severely as to result in marks, bruises, blood, broken bones, or broken teeth	Never	1-2 Times	More than 2 times
6	Witnessed someone with whom you were <u>not</u> so close deliberately attack one or your family member's that severely	Never	1-2 Times	More than 2 times

1. <u>Before the age of 18</u>, were you attacked by someone with whom <u>you were very close</u> so severely as to result in marks, bruises, blood, broken bones, or broken teeth? ☐ Yes ☐ No

If <u>YES</u>, please answer the following questions.
If <u>NO</u>, please skip to the next page.

2. How many different people did this to you? Please enter a number here _____.

3. If more than one person did this to you, please <u>select the person involved in the most significant or distressing event(s)</u> and answer the rest of the questions for that person. The person who did this to you was (Please check all that apply):

☐ Male	☐ Parent, guardian, or caregiver	☐ Husband, wife, or romantic partner	☐ Someone you NEVER trusted at any point in your life
☐ Female	☐ Family member not responsible for caring for you	☐ Babysitter or nanny	☐ Someone you trusted at some point in your life
☐ Friend	☐ Acquaintance	☐ Stranger	☐ Teacher, doctor, coach, religious advisor, counselor or professional

4. Have you told anyone about this experience? ☐ Yes ☐ No
5. Did people find out about it in a different way? ☐ Yes ☐ No

If <u>NO</u> to <u>both</u> #4 AND #5, please skip to the next page.

Below is a list of ways that people may have behaved toward you after they found out about the experience. Please circle the number that best describes how often you experienced each of the following.

Reacted to your story with disbelief	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Made light of or minimized the actions of the person who did this to you	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Made direct sexual advances toward you	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Reacted in a threatening or hostile manner toward you	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Denied the experience occurred	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Actively showed disapproval of the actions of the person who did this to you, for example, by seeking a separation, forcing that person to seek treatment, cooperating with the legal system to get him/her prosecuted	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Remained passive, refused to take sides	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Chose the side of the person who did this to you over you/took his/her side at your expense	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Reacted with embarrassment or disgust	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Accused you of fantasizing, lying, or making it up	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Helped stop the experience from happening again	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Told you that you must have enjoyed it because it went on for so long	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS

1. <u>Before the age of 18</u>, were you attacked by someone with whom you were <u>not</u> so close so severely as to result in marks, bruises, blood, broken bones, or broken teeth? □ Yes □ No

<center>If <u>YES</u>, please answer the following questions.
If <u>NO</u>, please skip to the next page.</center>

2. How many different people did this to you? Please enter a number here _____.

3. If more than one person did this to you, please **select the person involved in the most significant or distressing event(s)** and answer the rest of the questions for that person. The person who did this to you was (please check all that apply):

□ Male	□ Parent, guardian, or caregiver	□ Husband, wife, or romantic partner	□ Someone you NEVER trusted at any point in your life
□ Female	□ Family member not responsible for caring for you	□ Babysitter or nanny	□ Someone you trusted at some point in your life
□ Friend	□ Acquaintance	□ Stranger	□ Teacher, doctor, coach, religious advisor, counselor or professional

4. Have you told anyone about this experience? □ Yes □ No
5. Did people find out about it in a different way? □ Yes □ No

<center>If <u>NO</u> to <u>both</u> #4 AND #5, please skip to the next page.</center>

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Helped stop the experience from happening again	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Told you that you must have enjoyed it because it went on for so long	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS

1. <u>Before the age of 18</u>, were you were made to have some form of sexual contact, such as touching or penetration, by someone with whom <u>you were very close</u> (such as a family member or lover)?

<p align="center">☐ Yes ☐ No</p>

<p align="center">If <u>YES</u>, please answer the following questions.
If <u>NO</u>, please skip to the next page.</p>

4. How many different people did this to you? Please enter a number here _____.

5. If more than one person did this to you, please <u>select the person involved in the most significant or distressing event(s)</u> and answer the rest of the questions for that person. The person who did this to you was (please check all that apply):

☐ Male	☐ Parent, guardian, or caregiver	☐ Husband, wife, or romantic partner	☐ Someone you NEVER trusted at any point in your life
☐ Female	☐ Family member not responsible for caring for you	☐ Babysitter or nanny	☐ Someone you trusted at some point in your life
☐ Friend	☐ Acquaintance	☐ Stranger	☐ Teacher, doctor, coach, religious advisor, counselor or professional

4. Have you told anyone about this experience?   ☐ Yes   ☐ No
5. Did people find out about it in a different way?   ☐ Yes   ☐ No

<p align="center">If <u>NO</u> to <u>both</u> #4 AND #5, please skip to the next page.</p>

Below is a list of ways that people may have behaved toward you after they found out about the experience. Please circle the number that best describes how often you experienced each of the following.

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Denied the experience occurred	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Actively showed disapproval of the actions of the person who did this to you, for example, by seeking a separation, forcing that person to seek treatment, cooperating with the legal system to get him/her prosecuted	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
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Chose the side of the person who did this to you over you/took his/her side at your expense	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
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1. <u>Before the age of 18</u>. were you were made to have some form of sexual contact. such as touching or penetration, by someone with whom you were <u>not</u> so close (such as a family member or lover)?

<center>☐ Yes ☐ No</center>

<center>If <u>YES</u>, please answer the following questions.
If <u>NO</u>. please skip to the next page.</center>

2. How many different people did this to you? Please enter a number here _____.

3. If more than one person did this to you, please <u>select the person involved in the most significant or distressing event(s)</u> and answer the rest of the questions for that person. The person who did this to you was (please check all that apply):

☐ Male	☐ Parent, guardian, or caregiver	☐ Husband. wife, or romantic partner	☐ Someone you NEVER trusted at any point in your life
☐ Female	☐ Family member not responsible for caring for you	☐ Babysitter or nanny	☐ Someone you trusted at some point in your life
☐ Friend	☐ Acquaintance	☐ Stranger	☐ Teacher, doctor, coach, religious advisor, counselor or professional

4. Have you told anyone about this experience?   ☐ Yes   ☐ No
5. Did people find out about it in a different way?   ☐ Yes   ☐ No

<center>If <u>NO</u> to <u>both</u> #4 AND #5. please skip to the next page.</center>

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Told you that you must have enjoyed it because it went on for so long	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS

1. <u>Before the age of 18</u>, were you emotionally or psychologically mistreated over a significant period of time by someone with whom <u>you were very close</u> (such as a family member or lover)?

<center>☐ Yes ☐ No</center>

<center>If <u>YES</u>, please answer the following questions.
If <u>NO</u>, please skip to the next page.</center>

2. How many different people did this to you? Please enter a number here _____.

3. If more than one person did this to you, please <u>select the person involved in the most significant or distressing event(s)</u> and answer the rest of the questions for that person. The person who did this to you was (please check all that apply):

☐ Male	☐ Parent, guardian, or caregiver	☐ Husband, wife, or romantic partner	☐ Someone you NEVER trusted at any point in your life
☐ Female	☐ Family member not responsible for caring for you	☐ Babysitter or nanny	☐ Someone you trusted at some point in your life
☐ Friend	☐ Acquaintance	☐ Stranger	☐ Teacher, doctor, coach, religious advisor, counselor or professional

4. Have you told anyone about this experience?   ☐ Yes   ☐ No
5. Did people find out about it in a different way?   ☐ Yes   ☐ No

<center>If <u>NO</u> to <u>both</u> #4 AND #5, please skip to the next page</center>

Below is a list of ways that people may have behaved toward you after they found out about the experience. Please circle the number that best describes how often you experienced each of the following.

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Told you that you must have enjoyed it because it went on for so long	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS

1. <u>Before the age of 18.</u> were you emotionally or psychologically mistreated over a significant period of time by someone with whom you were <u>not</u> so close (such as a family member or lover)?

<div align="center">

☐ Yes ☐ No

If <u>YES</u>, please answer the following questions.
If <u>NO</u>, please skip to the next page.

</div>

2. How many different people did this to you? Please enter a number here _____.

3. If more than one person did this to you, please **select the person involved in the most significant or distressing event(s)** and answer the rest of the questions for that person. The person who did this to you was (please check all that apply):

☐ Male	☐ Parent, guardian, or caregiver	☐ Husband, wife, or romantic partner	☐ Someone you NEVER trusted at any point in your life
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☐ Friend	☐ Acquaintance	☐ Stranger	☐ Teacher, doctor, coach, religious advisor, counselor or professional

4. Have you told anyone about this experience? ☐ Yes ☐ No
5. Did people find out about it in a different way? ☐ Yes ☐ No

<div align="center">

If <u>NO</u> to <u>both</u> #4 AND #5, please skip to the next page.

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Helped stop the experience from happening again	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Told you that you must have enjoyed it because it went on for so long	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS

1. <u>Before the age of 18</u>, did you experience a seriously traumatic event not already covered in any of these questions?

<div align="center">☐ Yes ☐ No</div>

<div align="center">If <u>YES</u>, please answer the following questions.
If <u>NO</u>, please skip to the next page.</div>

2. How many different people did this to you? Please enter a number here _____.

3. If more than one person did this to you, please <u>select the person involved in the most significant or distressing event(s)</u> and answer the rest of the questions for that person. The person who did this to you was (please check all that apply):

☐ Male	☐ Parent, guardian, or caregiver	☐ Husband, wife, or romantic partner	☐ Someone you NEVER trusted at any point in your life
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☐ Friend	☐ Acquaintance	☐ Stranger	☐ Teacher, doctor, coach, religious advisor, counselor or professional

4. Please describe the experience(s) in the space below:

5. Have you told anyone about this experience?   ☐ Yes   ☐ No
6. Did people find out about it in a different way?   ☐ Yes   ☐ No

<div align="center">If <u>NO</u> to <u>both</u> #5 AND #6, please skip to the next page.</div>

7. Please describe the types of reactions that you received when you told people and/or they found out in a different way:

When you were age 18 or older, how often did each of the following events happen to you?

1. Been in a major earthquake, fire, flood, hurricane, or tornado that resulted in significant loss of personal property, serious injury to yourself or a significant other, the death of a significant other, or the fear of your own death

   Never   1-2 Times   More than 2 times

2. Been in a major automobile, boat, motorcycle, plane, train, or industrial accident tat resulted in significant loss of personal property, serious injury to yourself or a significant other, the death of a significant other, or the fear of your own death

   Never   1-2 Times   More than 2 times

3. Witnessed someone with whom <u>you were very close</u> (such as a parent, sibling, caregiver, or intimate partner) committing suicide, being killed, or being injured by another person so severely as to result in marks, bruises, burns, blood, or broken bones. This might include a close friend in combat.

   Never   1-2 Times   More than 2 times

4. Witnessed someone with whom you were <u>not</u> so close undergoing a similar kind of traumatic event.

   Never   1-2 Times   More than 2 times

5. Witnessed someone with whom <u>you were very close</u> deliberately attack one or more of your family member's so severely as to result in marks, bruises, blood, broken bones, or broken teeth

   Never   1-2 Times   More than 2 times

6. Witnessed someone with whom you were <u>not</u> so close deliberately attack one or your family member's that severely

   Never   1-2 Times   More than 2 times

1. When you were <u>age 18 or older,</u> were you attacked by someone with whom <u>you were very close</u> so severely as to result in marks, bruises, blood, broken bones, or broken teeth?

<div align="center">☐ Yes   ☐ No</div>

<div align="center">If <u>YES</u>, please answer the following questions.
If <u>NO</u>, please skip to the next page.</div>

2. How many different people did this to you? Please enter a number here _____.

3. If more than one person did this to you, please <u>select the person involved in the most significant or distressing event(s)</u> and answer the rest of the questions for that person. The person who did this to you was (Please check all that apply):

☐ Male	☐ Parent, guardian, or caregiver	☐ Husband, wife, or romantic partner	☐ Someone you NEVER trusted at any point in your life
☐ Female	☐ Family member not responsible for caring for you	☐ Babysitter or nanny	☐ Someone you trusted at some point in your life
☐ Friend	☐ Acquaintance	☐ Stranger	☐ Teacher, doctor, coach, religious advisor, counselor or professional

4. Have you told anyone about this experience?   ☐ Yes   ☐ No
5. Did people find out about it in a different way?   ☐ Yes   ☐ No

<div align="center">If <u>NO</u> to <u>both</u> #4 AND #5, please skip to the next page.</div>

Below is a list of ways that people may have behaved toward you after they found out about the experience. Please circle the number that best describes how often you experienced each of the following.

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Reacted in a threatening or hostile manner toward you	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Denied the experience occurred	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Actively showed disapproval of the actions of the person who did this to you, for example, by seeking a separation, forcing that person to seek treatment, cooperating with the legal system to get him/her prosecuted	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Remained passive, refused to take sides	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Chose the side of the person who did this to you over you/took his/her side at your expense	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Reacted with embarrassment or disgust	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Accused you of fantasizing, lying, or making it up	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Helped stop the experience from happening again	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Told you that you must have enjoyed it because it went on for so long	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS

1. When you were age 18 or older, were you attacked by someone with whom you were not so close so severely as to result in marks, bruises, blood, broken bones, or broken teeth?   ☐ Yes   ☐ No

    If YES, please answer the following questions.
    If NO, please skip to the next page.

2. How many different people did this to you? Please enter a number here _____.

3. If more than one person did this to you, please select the person involved in the most significant or distressing event(s) and answer the rest of the questions for that person. The person who did this to you was (please check all that apply):

☐ Male	☐ Parent, guardian, or caregiver	☐ Husband, wife, or romantic partner	☐ Someone you NEVER trusted at any point in your life
☐ Female	☐ Family member not responsible for caring for you	☐ Babysitter or nanny	☐ Someone you trusted at some point in your life
☐ Friend	☐ Acquaintance	☐ Stranger	☐ Teacher, doctor, coach, religious advisor, counselor or professional

4. Have you told anyone about this experience?   ☐ Yes   ☐ No
5. Did people find out about it in a different way?   ☐ Yes   ☐ No

    If NO to both #4 AND #5, please skip to the next page.

Below is a list of ways that people may have behaved toward you after they found out about the experience. Please circle the number that best describes how often you experienced each of the following.

Reacted to your story with disbelief	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Made light of or minimized the actions of the person who did this to you	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Made direct sexual advances toward you	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Reacted in a threatening or hostile manner toward you	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Denied the experience occurred	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Actively showed disapproval of the actions of the person who did this to you, for example, by seeking a separation, forcing that person to seek treatment, cooperating with the legal system to get him/her prosecuted	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Remained passive, refused to take sides	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Chose the side of the person who did this to you over you/took his/her side at your expense	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Reacted with embarrassment or disgust	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Accused you of fantasizing, lying, or making it up	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Helped stop the experience from happening again	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Told you that you must have enjoyed it because it went on for so long	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS

1. When you were age 18 or older, were you were made to have some form of sexual contact, such as touching or penetration, by someone with whom you were very close (such as a family member or lover)? □ Yes   □ No

<div align="center">
If YES, please answer the following questions.
If NO, please skip to the next page.
</div>

2. How many different people did this to you? Please enter a number here _____.

3. If more than one person did this to you, please select the person involved in the most significant or distressing event(s) and answer the rest of the questions for that person. The person who did this to you was (please check all that apply):

□ Male	□ Parent, guardian, or caregiver	□ Husband, wife, or romantic partner	□ Someone you NEVER trusted at any point in your life
□ Female	□ Family member not responsible for caring for you	□ Babysitter or nanny	□ Someone you trusted at some point in your life
□ Friend	□ Acquaintance	□ Stranger	□ Teacher, doctor, coach, religious advisor, counselor or professional

4. Have you told anyone about this experience?   □ Yes   □ No
5. Did people find out about it in a different way?   □ Yes   □ No

<div align="center">
If NO to both #4 AND #5, please skip to the next page.
</div>

Below is a list of ways that people may have behaved toward you after they found out about the experience. Please circle the number that best describes how often you experienced each of the following.

Reacted to your story with disbelief	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
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Reacted in a threatening or hostile manner toward you	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Denied the experience occurred	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Actively showed disapproval of the actions of the person who did this to you, for example, by seeking a separation, forcing that person to seek treatment, cooperating with the legal system to get him/her prosecuted	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Remained passive, refused to take sides	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Chose the side of the person who did this to you over you/took his/her side at your expense	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
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Accused you of fantasizing, lying, or making it up	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Helped stop the experience from happening again	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Told you that you must have enjoyed it because it went on for so long	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS

1. When you were <u>age 18 or older</u>, were you were made to have some form of sexual contact, such as touching or penetration, by someone with whom you were <u>not</u> so close (such as a family member or lover)?   ☐ Yes   ☐ No

<div align="center">

If <u>YES</u>, please answer the following questions.
If <u>NO</u>, please skip to the next page.

</div>

2. How many different people did this to you? Please enter a number here _____.

3. If more than one person did this to you, please <u>select the person involved in the most significant or distressing event(s)</u> and answer the rest of the questions for that person. The person who did this to you was (please check all that apply):

☐ Male	☐ Parent, guardian, or caregiver	☐ Husband, wife, or romantic partner	☐ Someone you NEVER trusted at any point in your life
☐ Female	☐ Family member not responsible for caring for you	☐ Babysitter or nanny	☐ Someone you trusted at some point in your life
☐ Friend	☐ Acquaintance	☐ Stranger	☐ Teacher, doctor, coach, religious advisor, counselor or professional

4. Have you told anyone about this experience?   ☐ Yes   ☐ No
5. Did people find out about it in a different way?   ☐ Yes   ☐ No

<div align="center">

If <u>NO</u> to <u>both</u> #4 AND #5, please skip to the next page.

</div>

Below is a list of ways that people may have behaved toward you after they found out about the experience. Please circle the number that best describes how often you experienced each of the following.

Reacted to your story with disbelief	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
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Made direct sexual advances toward you	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Reacted in a threatening or hostile manner toward you	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Denied the experience occurred	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Actively showed disapproval of the actions of the person who did this to you, for example, by seeking a separation, forcing that person to seek treatment, cooperating with the legal system to get him/her prosecuted	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
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Helped stop the experience from happening again	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Told you that you must have enjoyed it because it went on for so long	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS

1. When you were age 18 or older, were you emotionally or psychologically mistreated over a significant period of time by someone with whom you were very close (such as a family member or lover)? ☐ Yes ☐ No

If YES, please answer the following questions.
If NO, please skip to the next page.

2. How many different people did this to you? Please enter a number here _____.

3. If more than one person did this to you, please select the person involved in the most significant or distressing event(s) and answer the rest of the questions for that person. The person who did this to you was (please check all that apply):

☐ Male	☐ Parent, guardian, or caregiver	☐ Husband, wife, or romantic partner	☐ Someone you NEVER trusted at any point in your life
☐ Female	☐ Family member not responsible for caring for you	☐ Babysitter or nanny	☐ Someone you trusted at some point in your life
☐ Friend	☐ Acquaintance	☐ Stranger	☐ Teacher, doctor, coach, religious advisor, counselor or professional

4. Have you told anyone about this experience?   ☐ Yes   ☐ No
5. Did people find out about it in a different way?   ☐ Yes   ☐ No

If NO to both #4 AND #5, please skip to the next page.

Below is a list of ways that people may have behaved toward you after they found out about the experience. Please circle the number that best describes how often you experienced each of the following.

Reacted to your story with disbelief	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
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Made direct sexual advances toward you	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Reacted in a threatening or hostile manner toward you	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Denied the experience occurred	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Actively showed disapproval of the actions of the person who did this to you, for example, by seeking a separation, forcing that person to seek treatment, cooperating with the legal system to get him/her prosecuted	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
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Chose the side of the person who did this to you over you/took his/her side at your expense	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Reacted with embarrassment or disgust	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Accused you of fantasizing, lying, or making it up	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Helped stop the experience from happening again	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Told you that you must have enjoyed it because it went on for so long	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS

1. When you were <u>age 18 or older</u>, were you emotionally or psychologically mistreated over a significant period of time by someone with whom you were <u>not</u> so close (such as a family member or lover)? ☐ Yes ☐ No

If <u>YES</u>, please answer the following questions.
If <u>NO</u>, please skip to the next page.

2. How many different people did this to you? Please enter a number here _____.

3. If more than one person did this to you, please <u>select the person involved in the most significant or distressing event(s)</u> and answer the rest of the questions for that person. The person who did this to you was (please check all that apply):

☐ Male	☐ Parent, guardian, or caregiver	☐ Husband, wife, or romantic partner	☐ Someone you NEVER trusted at any point in your life
☐ Female	☐ Family member not responsible for caring for you	☐ Babysitter or nanny	☐ Someone you trusted at some point in your life
☐ Friend	☐ Acquaintance	☐ Stranger	☐ Teacher, doctor, coach, religious advisor, counselor or professional

4. Have you told anyone about this experience? ☐ Yes ☐ No
5. Did people find out about it in a different way? ☐ Yes ☐ No

If <u>NO</u> to <u>both</u> #4 AND #5, please skip to the next page.

Below is a list of ways that people may have behaved toward you after they found out about the experience. Please circle the number that best describes how often you experienced each of the following.

Reacted to your story with disbelief	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Made light of or minimized the actions of the person who did this to you	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
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Reacted in a threatening or hostile manner toward you	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Denied the experience occurred	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Actively showed disapproval of the actions of the person who did this to you, for example, by seeking a separation, forcing that person to seek treatment, cooperating with the legal system to get him/her prosecuted	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Remained passive, refused to take sides	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Chose the side of the person who did this to you over you/took his/her side at your expense	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Reacted with embarrassment or disgust	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Accused you of fantasizing, lying, or making it up	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Helped stop the experience from happening again	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS
Told you that you must have enjoyed it because it went on for so long	NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS

1. When you were <u>age 18 or older</u>, did you experience a seriously traumatic event not already covered in any of these questions?   □ Yes   □ No

<div align="center">

If <u>YES</u>, please answer the following questions.
If <u>NO</u>, please skip to the next page.

</div>

2. How many different people did this to you? Please enter a number here _____.

3. If more than one person did this to you, please <u>select the person involved in the most significant or distressing event(s)</u> and answer the rest of the questions for that person. The person who did this to you was (please check all that apply):

□ Male	□ Parent, guardian, or caregiver	□ Husband, wife, or romantic partner	□ Someone you NEVER trusted at any point in your life
□ Female	□ Family member not responsible for caring for you	□ Babysitter or nanny	□ Someone you trusted at some point in your life
□ Friend	□ Acquaintance	□ Stranger	□ Teacher, doctor, coach, religious advisor, counselor or professional

4. Please describe the experience(s) in the space below:

5. Have you told anyone about this experience?   □ Yes   □ No
6. Did people find out about it in a different way?   □ Yes   □ No

<div align="center">

If <u>NO</u> to <u>both</u> #5 AND #6, please skip to the next page.

</div>

7. Please describe the types of reactions that you received when you told people and/or they found out in a different way:

APPENDIX C

POST-DISCLOSURE QUESTIONNAIRE – PARTICIPANT A – STUDY 1

Post-Disclosure Questionnaire for Participant A.

1) How did you choose which event or experience to tell the other participant? (i.e. it was the easiest/most difficult to disclose, you had/hadn't told many people about this event or experience before, etc.)

2) Have you told other people about this event/experience before?　　Yes ☐　　　　No ☐

3) How do you feel this experience was overall?

4) How worried/anxious/stressed are you feeling now about life events (for example, school, work, finances, friends, family, etc.)?

       ☐ not at all
       ☐ slightly
       ☐ an average month
       ☐ more than average
       ☐ extremely

5) How would you describe your general mood now?

☐ great　　☐ good　　☐ average　　☐ poor　　☐ horrible

The following is a list of behaviors that other people responding to a person disclosing an experience often show. Please indicate the extent to which you feel you experienced each of the listed responses from the other participant by placing the appropriate number in the blank next to each item.

1	2	3	4	5
DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE

_____ 1. Distracted you with other things

_____ 2. Treated you differently in some way that made you feel uncomfortable

_____ 3. Encouraged you to seek counseling

_____ 4. Avoided talking to you or pulled away from you in some way

_____ 5. Listened to your feelings

_____ 6. Saw your side of things and did not make judgments

_____ 7. Told you that you could have done more to prevent the experience(s) from occurring

_____ 8. Minimized the importance or seriousness of your experience(s)

_____ 9. Said he/she knew how you felt when he/she really did not

_____ 10. Shared his/her own experience(s) with you

_____ 11. Told you that you did not do anything wrong

_____ 12. Made a joke or sarcastic comment about the experience(s)

_____ 13. Conveyed that he/she understood how you were feeling

_____ 14. Believed and/or accepted your account of what happened

_____ 15. Was so upset that he/she needed reassurance or calming down from you

_____ 16. Reassured you that you are a good person

_____ 17. Focused on his/her own needs and neglected yours

_____ 18. Said he/she felt personally wronged by your experience

_____ 19. Offered to help you get information of any kind about coping with the experience(s)

_____ 20. Offered information and discussed options

_____ 21. Encouraged you to keep the experience a secret

_____ 22. Encouraged you to move on with your life

_____ 23. Made you feel like you didn't know how to take care of yourself

_____ 24. Wanted to seek revenge on the person(s) who did something to you

_____ 25. Told you that it was not your fault and/or that you were not to blame

APPENDIX D

POST-DISCLOSURE QUESTIONNAIRE – PARTICIPANT B – STUDY 1

Post-Disclosure Questionnaire for Participant B.

1) Has someone ever told you about an event/experience like this before?   Yes ☐   No ☐

2) How do you feel this experience was overall?

3) If someone has told you about a similar event/experience before, do you feel your reaction was:

Similar ☐   Different ☐   Don't remember/Hard to say ☐

4) How worried/anxious/stressed are you feeling now about life events (for example, school, work, finances, friends, family, etc.)?

☐ not at all
☐ slightly
☐ an average month
☐ more than average
☐ extremely

5) How would you describe your general mood now?

☐ great   ☐ good   ☐ average   ☐ poor   ☐ horrible

The following is a list of behaviors that other people responding to a person disclosing an experience often show. Please indicate the extent to which you feel you responded to the other participant by placing the appropriate number in the blank next to each item.

1	2	3	4	5
DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE

_____ 1. Distracted him/her with other things

_____ 2. Treated him/her differently in some way that made him/her feel uncomfortable

_____ 3. Encouraged him/her to seek counseling

_____ 4. Avoided talking to him/her or pulled away from him/her in some way

_____ 5. Listened to his/her feelings

_____ 6. Saw his/her side of things and did not make judgments

_____ 7. Told him/her that he/she could have done more to prevent the experience(s) from occurring

_____ 8. Minimized the importance or seriousness of his/her experience(s)

_____ 9. Said you knew how she/he felt when you really did not

_____ 10. Shared your own experience(s) with him/her

_____ 11. Told him/her that he/she did not do anything wrong

_____ 12. Made a joke or sarcastic comment about the experience(s)

_____ 13. Conveyed that you understood how he/she was feeling

_____ 14. Believed and/or accepted his/her account of what happened

_____ 15. Were so upset that you needed reassurance or calming down from him/her

_____ 16. Reassured him/her that he/she is a good person

_____ 17. Focused on your own needs and neglected his/hers

_____ 18. Said you felt personally wronged by his/her experience

_____ 19. Offered to help him/her get information of any kind about coping with the experience(s)

_____ 20. Offered information and discussed options

_____ 21. Encouraged him/her to keep the experience a secret

_____ 22. Encouraged him/her to move on with his/her life

_____ 23. Made him/her feel like he/she didn't know how to take care of himself/herself

_____ 24. Wanted to seek revenge on the person(s) who did something to him/her

_____ 25. Told him/her that it was not his/her fault and/or that he/she was not to blame

APPENDIX E

ORIGINAL CODING SCHEME – STUDY 1

NAME: _____

DATE: _____

PARTICIPANT ID NUMERS _____

Please read the following statements and carefully check off the circle that best describes how much you agree with each statement.

How much do you agree?

	not at all							very much
	0	1	2	3	4	5	6	7	8

The Listener:

	not at all 0 1 2 3 4 5 6 7 8 very much
1) explicitly and/or implicitly promoted disclosure.	O O O O O O O O O 0 1 2 3 4 5 6 7 8
2) conveyed support (e.g.. warmth, validation, respect, openness).	O O O O O O O O O 0 1 2 3 4 5 6 7 8
3) seemed to really listen to the other person (e.g. body posture, eye contact).	O O O O O O O O O 0 1 2 3 4 5 6 7 8
4) asked questions and/or made comments that seemed to derail/distract discloser from talking about the chosen topic.	O O O O O O O O O 0 1 2 3 4 5 6 7 8
5) asked questions and/or made comments that seemed to help discloser continue talking about the chosen topic.	O O O O O O O O O 0 1 2 3 4 5 6 7 8
6) was moving in a way that seemed distracting to the discloser (e.g. fidgeting, tapping, playing with cell phone)	O O O O O O O O O 0 1 2 3 4 5 6 7 8

The Discloser's:

	not at all 0 1 2 3 4 5 6 7 8 very much
1) willingness to disclose increased as time went on. (e.g. less hesitation).	O O O O O O O O O 0 1 2 3 4 5 6 7 8
2) willingness to disclose decreased as time went on (e.g. more hesitation).	O O O O O O O O O 0 1 2 3 4 5 6 7 8
3) willingness to disclose seemed derailed/distracted by the listener's movements.	O O O O O O O O O 0 1 2 3 4 5 6 7 8

The following is a list of behaviors that other people responding to a person disclosing an experience often show. Please indicate the extent to which you feel the listener demonstrated each of the listed responses by circling the most appropriate response.

If something is not present or not applicable, select "DISAGREE." IF the response is a little of both (e.g. a little present, a little not present, or sort of present, sort of not) then select "NEUTRAL."

1. Distracted discloser with other things	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
2. Treated discloser differently in some way that made the discloser feel uncomfortable	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
3. Encouraged discloser to seek counseling	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
4. Avoided talking to discloser or pulled away from discloser in some way	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
5. Listened to discloser's feelings	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
6. Saw discloser's side of things and did not make judgments	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
7. Told discloser that he/she could have done more to prevent the experience(s) from occurring	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
8. Minimized the importance or seriousness of discloser's experience(s)	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
9. Said he/she knew how the discloser felt when it seemed that he/she really did not	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
10. Shared his/her own experience(s) with discloser	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
11. Told discloser that he/she did not do anything wrong	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
12. Made a joke or sarcastic comment about the experience(s)	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
13. Conveyed that he/she understood how the discloser was feeling	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
14. Believed and/or accepted discloser's account of what happened	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
15. Was so upset that he/she needed reassurance or calming down from discloser	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
16. Reassured discloser that he/she is a good person	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
17. Focused on his/her own needs and neglected discloser's	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
18. Said he/she felt personally wronged by discloser's experience	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
19. Offered to help discloser get information of any kind about coping with the experience(s)	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
20. Offered information and discussed options	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
21. Encouraged discloser to keep the experience a secret	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
22. Encouraged discloser to move on with his/her life	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE

23. Made discloser feel like he/she didn't know how to take care of himself/herself	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
24. Wanted to seek revenge on the person(s) who did something to discloser	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
25. Told discloser that it was not his/her fault and/or that he/she was not to blame	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE

Please rate the posture of both listener and discloser below; multiple items can be circled:

When the discloser started talking.

a) The listener was	Sitting Upright	Leaning to the Left	Leaning to the Right	Leaning Backward	Leaning Forward
b) The discloser was	Sitting Upright	Leaning to the Left	Leaning to the Right	Leaning Backward	Leaning Forward

Three minutes into the conversation.

a) The listener was	Sitting Upright	Leaning to the Left	Leaning to the Right	Leaning Backward	Leaning Forward
b) The discloser was	Sitting Upright	Leaning to the Left	Leaning to the Right	Leaning Backward	Leaning Forward

Six minutes into the conversation.

a) The listener was	Sitting Upright	Leaning to the Left	Leaning to the Right	Leaning Backward	Leaning Forward
b) The discloser was	Sitting Upright	Leaning to the Left	Leaning to the Right	Leaning Backward	Leaning Forward

In the space below please tally the number of times the listener interrupts the discloser – even if he/she interrupts to do or say something that seems supportive. This includes BOTH verbal and nonverbal interruptions; interruptions are considered as such based on the impact of the behavior/sound on the discloser.

Please read the following statements and carefully check off the circle that best describes how much you agree with each statement.

How much do you agree?

	not at all							very much

The Listener:

	0	1	2	3	4	5	6	7	8
1) explicitly and/or implicitly promoted disclosure.	○	○	○	○	○	○	○	○	
2) conveyed support (e.g., warmth, validation, respect, openness).	○	○	○	○	○	○	○	○	
3) seemed to really listen to the other person (e.g. body posture, eye contact).	○	○	○	○	○	○	○	○	
4) asked questions and/or made comments that seemed to derail/distract discloser from talking about the chosen topic.	○	○	○	○	○	○	○	○	
5) asked questions and/or made comments that seemed to help discloser continue talking about the chosen topic.	○	○	○	○	○	○	○	○	
6) was moving in a way that seemed distracting to the discloser (e.g. fidgeting, tapping, playing with cell phone)	○	○	○	○	○	○	○	○	

The Discloser's:

	0	1	2	3	4	5	6	7	8
1) willingness to disclose increased as time went on (e.g. less hesitation).	○	○	○	○	○	○	○	○	
2) willingness to disclose decreased as time went on (e.g. more hesitation).	○	○	○	○	○	○	○	○	
3) willingness to disclose seemed derailed/distracted by the listener's movements.	○	○	○	○	○	○	○	○	

Please use the space below to write down your impressions of this interaction in particular and your experience with coding it (i.e What did you notice in this tape? What are we missing/not getting at with this coding system?)

APPENDIX F

FINAL CODING SCHEME – STUDY 1

NAME: _____

DATE: _____

PARTICIPANT ID NUMERS _____

TIME RECORDING BEGINS:_____

The following is a list of behaviors that other people responding to a person disclosing an experience often show. Please indicate the extent to which you feel the listener demonstrated each of the listed responses by circling the most appropriate response.

If something is not present or not applicable, select "DISAGREE." IF the response is a little of both (e.g. a little present, a little not present, OR sort of present, sort of not) then select "NEUTRAL".

1. Distracted discloser with other things	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
2. Treated discloser differently in some way that made the discloser feel uncomfortable	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
3. Avoided talking to discloser or pulled away from discloser in some way	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
4. Saw discloser's side of things and did not make judgments	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
5. Told discloser that he/she could have done more to prevent the experience(s) from occurring	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
6. Minimized the importance or seriousness of discloser's experience(s)	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
7. Shared his/her own experience(s) with discloser	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
8. Told discloser that he/she did not do anything wrong	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
9. Reassured discloser that he/she is a good person	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
10. Focused on his/her own needs and neglected discloser's	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE
11. Told discloser that it was not his/her fault and/or that he/she was not to blame	DISAGREE	SLIGHTLY DISAGREE	NEUTRAL	SLIGHTLY AGREE	AGREE

Please rate the posture of both listener and discloser below; PLEASE SELECT ONLY ONE!!!
When the discloser started talking,

a) The listener was	Sitting Upright	Leaning to the Left	Leaning to the Right	Leaning Backward	Leaning Forward

b) The discloser was	Sitting Upright	Leaning to the Left	Leaning to the Right	Leaning Backward	Leaning Forward

Three minutes into the conversation,

a) The listener was	Sitting Upright	Leaning to the Left	Leaning to the Right	Leaning Backward	Leaning Forward

b) The discloser was	Sitting Upright	Leaning to the Left	Leaning to the Right	Leaning Backward	Leaning Forward

Six minutes into the conversation,

a) The listener was	Sitting Upright	Leaning to the Left	Leaning to the Right	Leaning Backward	Leaning Forward

b) The discloser was	Sitting Upright	Leaning to the Left	Leaning to the Right	Leaning Backward	Leaning Forward

In the space below please tally the number of times the listener interrupts the discloser – even if he/she interrupts to do or say something that seems supportive. This includes BOTH verbal and nonverbal interruptions; interruptions are considered as such based on the impact of the behavior/sound on the discloser. If the discloser does not seem "interrupted" this is not an interruption :o)

Please read the following statements and carefully check off the circle that best describes how much you agree with each statement.

How much do you agree?

	not at all								very much

The Listener:

	0	1	2	3	4	5	6	7	8
1) explicitly and/or implicitly promoted disclosure.	○	○	○	○	○	○	○	○	○
2) conveyed support (e.g.. warmth, validation, respect, openness).	○	○	○	○	○	○	○	○	○
3) seemed to really listen to the other person (e.g. body posture, eye contact).	○	○	○	○	○	○	○	○	○
4) asked questions and/or made comments that seemed to derail/distract discloser from talking about the chosen topic.	○	○	○	○	○	○	○	○	○
5) was moving in a way that seemed distracting to the discloser (e.g. fidgeting, tapping, playing with cell phone)	○	○	○	○	○	○	○	○	○

The Discloser's:

	0	1	2	3	4	5	6	7	8
1) willingness to disclose increased as time went on (e.g. less hesitation).	○	○	○	○	○	○	○	○	○
2) willingness to disclose decreased as time went on (e.g. more hesitation).	○	○	○	○	○	○	○	○	○

Please use the space below to write down your impressions of this interaction in particular and your experience with coding it (i.e.What did you notice in this tape? What are we missing not getting at with this coding system?)

APPENDIX G

SAMPLE PAGE FROM BETRAYAL TRAUMA INVENTORY – STUDY 2

1. <u>Before the age of 18</u>, were you attacked by someone with whom <u>you were very close</u> (such as a family member or romantic partner) so severely as to result in marks, bruises, blood, broken bones, or broken teeth?

☐ Yes ☐ No

If <u>YES</u>, please answer the following questions.
If <u>NO</u>, please skip to the next page.

2. How many different people did this to you? Please enter a number here _____.

3. If more than one person did this to you, please <u>select the person involved in the most significant or distressing event(s)</u> and answer the rest of the questions for that person. The person who did this to you was (Please check all that apply):

a). ☐ Male ☐ Female ☐ Other

b). ☐ Someone you NEVER trusted at any point in your life
☐ Someone you trusted at some point in your life

c). ☐ Parent, guardian, or person responsible for caring for you
☐ Family member not responsible for caring for you
☐ Neither

d). ☐ Husband, wife, or romantic partner
☐ Teacher, doctor, coach, religious advisor, counselor or professional
☐ Babysitter or nanny
☐ Acquaintance
☐ Friend
☐ Stranger
☐ Other (please specify _____).

4. Outside of this survey, have you ever told anyone about this experience? ☐ Yes ☐ No

a.) If yes, who was the first person that you told? (e.g family member, counselor, police, friend, romantic partner)

b.) If yes, how long after the experience did you *first* disclose that it happened?
☐ hours ☐ days ☐ weeks ☐ months ☐ years

c.) If yes, how did this person treat you once you told him/her what happened?

☐ very positively ☐ somewhat positively ☐ somewhat negatively ☐ very negatively

APPENDIX H

PSYCHOEDUCATIONAL MATERIALS – EXPERIMENTAL

We would like to give you some suggestions, based on prior research, to help you make your friend feel more comfortable during the experiment today. It is possible that these suggestions will also enhance the quality of your relationships. At the end of this explanation, you will be tested on this information since we believe it will be helpful for you to remember.

First, it is important to utilize attentive body language.
1) DO NOT make inappropriate facial expressions (Examples: smiling when someone is discussing a sad topic, rolling eyes, raising eyebrows when hearing how someone coped) and DO NOT move your body too much (Examples: excessive fidgeting, playing with cell phone).
2) DO sit in a posture (leaning forward or upright) and use gestures that convey engagement (nodding).
2) DO maintain consistent, not constant or darting, eye contact (look directly at the person for brief periods of 3-6 seconds, then look away briefly before reconnecting).

Second, it is important to use verbal skills that encourage the speaker to continue.
1) DO NOT change the topic or ask questions that are off-topic. This may seem like a way to decrease your anxiety or make the other person more comfortable, but it often has the opposite effect.
2) DO allow silence and convey that you are listening by using encouraging words like "hmmm" and "uh-huh" periodically.
3) DO state/name/reflect back the emotion being described. It might also help you to imagine yourself in the speaker's place and look at the situation from his/her perspective. (Examples: "Wow - sounds like it was scary for you." "It seems like you feel really sad about that." "I feel like that must've made you angry.")
4) DO ask questions if you are confused, and try to ask questions that require more than one word (Instead of: "Was that scary?" "Do you mean it wasn't that bad?" Ask questions like: "Could you tell me a little bit more about that?" "What was that like for you?" "What do you mean when you say ____?")

Third, it is important to use words in a way that convey support.
1) DO NOT reassure the person in a way that might minimize their experience (Examples: "That happened so long ago, maybe it would help to try move on." "It's not worth the energy to keep thinking about it." "Don't be scared.")
2) DO NOT make judgments or evaluations about their responses or decisions (Examples: "Couldn't you do/say _____ instead?" "I don't think you should worry about it anymore." "I think it'd be better for you to ____." "Why don't you ____?")
3) DO validate the person's emotions in a genuine tone (Examples: "If that happened to me, I can imagine I'd feel really overwhelmed too." "Given that experience, it makes sense you'd feel/say/do _____." "I think many people with that experience would have felt similarly.")
4) DO point out the person's strengths (Examples: "I'm amazed at how much courage that took." "You've done a great job at keeping everything in perspective." "I really admire your strength." "I'm impressed with how you've dealt with this.")
5) DO focus on their experience rather than your own and only give advice when it is requested.

APPENDIX I

PSYCHOEDUCATIONAL MATERIALS – CONTROL

We would like to give you some suggestions, based on prior research, to help you maintain a healthy lifestyle. It is possible that these suggestions will also enhance the quality of your relationships. At the end of this explanation, you will be tested on this information since we believe it will be helpful for you to remember.

First, it is important have adequate sleep hygiene.
1) DO NOT exercise within four hours of bedtime and DO NOT eat excessively before bed or go to bed on an empty stomach.
2) DO get enough restful and uninterrupted sleep by trying to go to bed only when sleepy and going to bed and waking up around the same time every day.
3) DO adhere to bedtime routines that will help give your body cues that it is time to slow down and sleep (Examples: listening to relaxing music, reading something soothing, having a cup of caffeine-free tea, and doing relaxation exercises).

Second, it is important to get a certain amount and type of exercise.
1) DO NOT skip warming up (Examples: stretching and doing a slower or toned down version of the exercise you are planning on doing) or cooling down (Examples: stretching and doing something that will decrease your heart rate gradually, like walking slowly) for at least 5 minutes. These may seem a waste of time but both are important for enhancing the effects of exercise and preventing soreness and injury.
2) DO incorporate both strength (Examples: weight-lifting, martial arts, Pilates) and flexibility (Examples: stretching, swimming, yoga) training in addition to the type of activity mentioned in #3.
3) DO aim to engage in physical activity that is either moderate-intensity (some increase in breathing or heart rate; conversation can occur comfortably during activity) for at least 30 minutes on 5 or more days per week OR high-intensity (large increase in breathing or heart rate; conversation is difficult because of being out of breath) for at least 20 minutes on 3 or more days per week.
4) DO drink enough water (Examples: 2 glasses of water both before and after exercise, and small amounts every 15-30 minutes) and eat at least 2 hours before exercise.

Third, it is important to work towards implementing a healthy diet.
1) DO NOT eat excessive amounts (eating in moderate frequency or moderate serving size is fine) of foods that are high in salt, saturated and trans fat, cholesterol, and added sugar (Examples: processed, prepared, and canned foods as well as some restaurant and fast foods).
2) DO NOT avoid protein (Examples: fish, poultry, eggs, beans, nut, meats) or healthy fats and oils (Examples: avocado, fish, olive & canola oil, raw nuts and seeds).
3) DO try to eat a sufficient amount and a large variety of fruits and vegetables (average of 2 cups of fruit and 2.5 cups of vegetables per day) especially those dark in color (Examples: dark green and orange).
4) DO eat at least 3 servings of whole grains per day (Examples: whole wheat instead of wheat flour, oatmeal, brown rice, quinoa).
5) DO consume 3 cups per day of milk or equivalent milk products (Examples: yogurt, cheese, or non-dairy calcium-containing alternatives).

APPENDIX J

PSYCHOEDUCATIONAL QUIZ – EXPERIMENTAL

Body Language

1. Indicate whether these statements are true or false based on the information you just studied by circling the best answer.

   It is recommended that you:

a.	Sit upright or leaning forward	True	False
b.	Maintain constant eye contact	True	False
c.	Avoid moving around	True	False
d.	Nod to show you are listening	True	False

2. Give two examples of inappropriate facial expressions.

   a. _____

   b. _____

Verbal Skills

3. Indicate whether these statements are true or false based on the information you just studied by circling the best answer.

   It is recommended that you:

a.	Only ask questions that require "yes" or "no" responses	True	False
b.	Avoid saying things like "hmmm" and "uh-huh"	True	False
c.	Try to look at the situation from your friend's perspective	True	False
d.	Change topics if your friend seems upset	True	False

4. Give two examples of how you might state, name, or reflect back emotions your friend describes.

   a. _____

   b. _____

Support

5. Indicate whether these statements are true or false based on the information you just studied by circling the best answer.

It is recommended that you:

a.	Talk about your own experiences if they are similar	True	False
b.	Give advice in a supportive tone	True	False
c.	Avoid reassuring your friend in a way that might minimize their situation	True	False
d.	Say things like, "Try not to worry about it"	True	False
e.	Avoid making judgments like, "I think it would be better for you to _____."	True	False

6. Give one example of a way to point out your friend's strengths and two examples of validating your friend's emotions.

a. Pointing out strengths: _____

b. Validating: _____

c. Validating _____

APPENDIX K

PSYCHOEDUCATIONAL QUIZ – CONTROL

Sleep Hygiene

1. Indicate whether these statements are true or false based on the information you just studied by circling the best answer.

   It is recommended that you:

a. Eat a small amount before sleeping if you are hungry	True	False
b. Try to go to sleep at night even if you are not tired	True	False
c. Keep a regular sleep schedule	True	False
d. Exercise 1-2 hours before bed to induce sleepiness	True	False

2. What are two examples of recommended bedtime routines?

   a. _____

   b. _____

Exercise

3. Indicate whether these statements are true or false based on the information you just studied by circling the best answer.

   It is recommended that you:

a. Exercise for 20-30 minutes on 3-5 days per week depending on intensity level	True	False
b. Drink water before, during, and after exercise	True	False
c. Eat 15-30 minutes before exercise for energy	True	False
d. Skip warm up/cool down if doing strength or flexibility training	True	False

4. Give one example of strength or flexibility training and one example of a warm-up or cool-down activity.

    a. Strength/Flexibility:_____

    b. Warm-up/Cool-down:_____

Balanced Eating

5. Indicate whether these statements are true or false based on the information you just studied by circling the best answer.

a.	Try to eat fruits and vegetables dark in color	True	False
b.	Completely eliminate foods high in salt, fat, cholesterol, or sugar	True	False
c.	Avoid foods with large amounts of protein	True	False
d.	Eat at least 3 servings of dairy and 3 servings of whole grain products per day	True	False
e.	Eat at least 2 cups of fruits and 2 cups of vegetables per day	True	False

6. Give one example of a recommended whole grain and two examples of recommended fats and oils.

    a. Whole grain:_____

    b. Fat/Oil:_____

    c. Fat/Oil:_____

APPENDIX L

FINAL CODER DOCUMENT – STUDY 2

NAME: _____

DATE: _____

PARTICIPANT ID NUMERS _____

TIME RECORDING BEGINS:_____

RATED: FIRST   SECOND

GENERAL TOPIC BEING DISCLOSED: _____

1) Instructions: Listed below are a number of responses the discloser may or may not have received from their friend (the listener) about the experience he/she discussed. For each statement, please circle the one number corresponding to *how much* of that type of response you think the discloser received from the listener during the interaction (*remember to consider both FREQUENCY and INTENSITY of the response).*

	None				A Lot
1. The listener thought the discloser was over-reacting	1	2	3	4	5
2. The listener did not give him/her enough of his or her time, or made the discloser feel like he/she should hurry (ex: changed topic, showed lack of interest, was silent in a way that indicated discloser should hurry)	1	2	3	4	5
3. The listener made "should or shouldn't have" comments about the discloser's role in the experience, such as, "You should/shouldn't have _____" (referring to the discloser's emotions OR actions)	1	2	3	4	5
4. The listener didn't seem to know what to say, or seemed afraid of saying/doing the "wrong" thing (ex: lacked confidence, seemed awkward, did or said something awkward or inappropriate, shifted in chair, stuttered, was hesitant to speak)	1	2	3	4	5
5. The listener refused to provide the type of help or support the discloser was looking for	1	2	3	4	5
6. The listener said the discloser should look on the bright side	1	2	3	4	5
7. The listener said, "I told you so," or made some similar comment (literal or figurative blaming, any comment with a blaming sentiment, write comment here to reflect upon later _____)	1	2	3	4	5
8. The listener seemed to be telling the discloser what he or she thought the listener wanted to hear (ex: cliché response, lack of genuineness, superficial comment/discussion, general platitudes)	1	2	3	4	5
9. The listener seemed disappointed in the discloser (ex: disappointment in regards to the topic the discloser chose to discuss or the discloser's response to the event, if the listener seems bored/inconvenienced)	1	2	3	4	5

	None				A Lot
10. The listener changed the subject before the discloser wanted to.	1	2	3	4	5
11. The listener felt that the discloser should stop worrying about the event and just forget about it.	1	2	3	4	5
12. The listener asked the discloser "why" questions about his/her role in the experience, such as, "Why did/didn't you _____?"	1	2	3	4	5
13. The listener felt that the discloser should focus on the present or the future (ex: that he/she should forget about what has happened and get on with his/her life)	1	2	3	4	5
14. The listener tried to cheer up the listener when he/she was not ready to cheer up	1	2	3	4	5
15. The listener refused to take the discloser seriously	1	2	3	4	5
16. The listener told the discloser to be strong, to keep his/her chin up, or said that the *discloser shouldn't let it bother him/her* (literal or figurative sentiment of "don't let it get to you", can be minimizing or patronizing)	1	2	3	4	5
17. The listener did not seem to want to hear about it	1	2	3	4	5
18. The listener told the discloser that he/she had gotten him/herself into the situation in the first place, and that the discloser now must deal with the consequences	1	2	3	4	5
19. The listener discouraged the discloser from expressing feelings such as anger, hurt or sadness	1	2	3	4	5
20. The listener felt that it could have been worse or that it was not as bad as the discloser thought	1	2	3	4	5
21. From the listener's tone of voice, expression, or body language, I got the feeling that he or she was uncomfortable talking with the discloser about his/her experience	1	2	3	4	5
22. The listener made comments that blamed the discloser, or tried to make the discloser feel responsible	1	2	3	4	5

2) Please rate the posture of both listener and discloser below; PLEASE SELECT ONLY ONE!!!

When the discloser started talking,

a) The listener was	Sitting Upright	Leaning to the Side	Leaning Backward	Leaning Forward
b) The discloser was	Sitting Upright	Leaning to the Side	Leaning Backward	Leaning Forward

Three minutes into the conversation,

a) The listener was	Sitting Upright	Leaning to the Side	Leaning Backward	Leaning Forward
b) The discloser was	Sitting Upright	Leaning to the Side	Leaning Backward	Leaning Forward

Six minutes into the conversation,

a) The listener was	Sitting Upright	Leaning to the Side	Leaning Backward	Leaning Forward
b) The discloser was	Sitting Upright	Leaning to the Side	Leaning Backward	Leaning Forward

3) In the space below please tally each of the following and refer to the instructions below.

INTERRUPTIONS
- Nonverbal behaviors need to distract/derail the discloser for them to be considered interruptions. Examples: nodding, or saying something like, "mmhmm," "really?" and other utterances indicating the person may be paying attention
- Verbal behaviors are considered interruptions *even if they do not distract/derail* the *discloser*. Examples: asking a question without a sufficient pause on the part of the discloser, talking at the same time of the discloser

TOPIC SWITCING - the # of times the topic is switched from the initial topic
- Do not consider different details of the same overall event as "switches"
- If the listener shares details about his or her life, this would be a topic switch only if it distracts the discloser in some way (e.g., if it seems like relating more than a "take over," probably not a switch)

ROLE SWITCHING - the # of times the listener becomes the discloser
- Consider listener disclosures as role switches ONLY if the listener seems to "take over" the conversation (e.g., if the listener shares one or two personal details as a way of relating, this most likely would not be a "role switch", but possibly a topic switch)

Interruptions	# of topic switches - D	# of topic switches - L	# of role switches

4) Please read the following statements and carefully check off the circle that best describes how much you agree with each statement in terms of global impressions.

How much do you agree?

	not at all								very much

The Listener:

1) explicitly and/or implicitly promoted disclosure.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9
2) conveyed support (e.g.. warmth, validation, respect, openness).	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9
3) seemed to really listen to the other person (e.g. body posture, eye contact).	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9
4) asked questions and/or made comments that seemed to derail/distract discloser from talking about each chosen topic.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9
5) asked questions and/or made comments that seemed to help discloser continue talking about each chosen topic.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9
6) was moving/moved in a way that seemed *distracting* to the discloser (e.g. fidgeting, tapping, playing with phone) OR exhibited *distracting* nonverbal behaviors (e.g., nodding, laughing, inappropriate facial expressions, listener's silence)	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9

The Discloser's:

1) willingness to disclose (in general) decreased as time went on (e.g. discloser seemed more hesitant).	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9
2) willingness to disclose (in general) seemed derailed/distracted by the listener's movements or nonverbal behaviors (e.g. nodding, laughing, inappropriate facial expressions)	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9

5) During the disclosure interaction, when the listener responded to the discloser, how much did his/her tone have each of the following characteristics taking into account **FREQUENCY AND INTENSITY**?

	None		Moderate Amount		A Lot
1) Varied or vivid changes in inflection	1	2	3	4	5
2) Weak and hesitant	1	2	3	4	5
3) Neutral with little feeling	1	2	3	4	5
4) Faltering or broken	1	2	3	4	5
5) Strong and confident	1	2	3	4	5

6) During the disclosure interaction, when the <u>discloser</u> was talking, how much did his/her tone have each of the following characteristics taking into account **FREQUENCY AND INTENSITY**?

	None		Moderate Amount		A Lot
1) Varied or vivid changes in inflection	1	2	3	4	5
2) Weak and hesitant	1	2	3	4	5
3) Neutral with little feeling	1	2	3	4	5
4) Faltering or broken	1	2	3	4	5
5) Strong and confident	1	2	3	4	5

7) During the disclosure interaction, how much did the <u>listener's</u> facial expressions reflect each of the following characteristics taking into account **FREQUENCY AND INTENSITY**?

	None		Moderate Amount		A Lot
1) Smile	1	2	3	4	5
2) Neutral	1	2	3	4	5
3) Rejection/Disgust	1	2	3	4	5
4) Acceptance	1	2	3	4	5
5) Sad face or frown	1	2	3	4	5
6) Anger	1	2	3	4	5
7) Alertness/Engagement	1	2	3	4	5
8) Wrinkled forehead	1	2	3	4	5
9) Disapproval	1	2	3	4	5

8) During the disclosure interaction, how much did the <u>discloser's</u> facial expressions reflect each of the following characteristics taking into account **FREQUENCY AND INTENSITY**?

	None		Moderate Amount		A Lot
1) Smile	1	2	3	4	5
2) Neutral	1	2	3	4	5
3) Rejection	1	2	3	4	5
4) Acceptance	1	2	3	4	5
5) Sad face or frown	1	2	3	4	5
6) Anger	1	2	3	4	5
7) Alertness/Engagement	1	2	3	4	5
8) Wrinkled forehead, biting lip	1	2	3	4	5
9) Disapproval	1	2	3	4	5

9) Please use the space below to write down your impressions of this interaction in particular and your experience with coding it (i.e., What did you notice in this tape? What are we missing/not getting at with this coding system?)

REFERENCES

Alaggia, R. (2004). Many ways of telling: expanding conceptualizations of child sexual abuse disclosure. *Child Abuse & Neglect, 28,* 1213-1227.

Allen R., Newman S.P., Souhami R.L. (1997). Anxiety and depression in adolescent cancer: Findings in patients and parents at time of diagnosis. *European Journal of Cancer, 33,* 1250-1255.

Ahrens, C. E. (2006). Being silenced: The impact of negative social reactions on the disclosure of rape. *American Journal of Community Psychology, 38,* 268-274.

Ahrens, C. E., Campbell, R., Ternier-Thames, N. K., Wasco, S. M., Sefl, T. (2007). Deciding whom to tell: Expectations and outcomes of rape survivors' first disclosures. *Psychology of Women Quarterly, 32,* 38-49.

Ancel, G. (2006). Developing empathy in nurses: an inservice training program. *Archives of Psychiatric Nursing, 20,* 249-257.

Baikie, K. A. & Wilhelm, K. (2005). Emotional and physical health benefits of expressive writing. *Advances in Psychiatric Treatment, 11,* 338–346.

Barkham, M. & Shapiro, D. A. (1986). Counselor verbal response modes and experienced empathy. *Journal of Counseling Psychology, 33,* 3-10.

Becker-Blease, K. A., Freyd, J. J., & Friend, D. (August, 2005). Male Victimization and Perpetration. Paper presented at the Annual Convention of the American Psychological Association, Washington, D.C., 18-21 August, 2005.

Befrienders International. (2000). Listening is everybody's business: Campaign for the promotion of listening: 'To lend an ear is to lend a hand.' *Crisis Columns, 21,* 52-54.

Birrell, P. J. & Freyd, J. J. (2006). Betrayal trauma: Relational models of harm and healing. *Journal of Trauma Practice, 5,* 49-63.

Bradley, R. G. & Follingstad, D. R. (2001). Utilizing disclosure in the treatment of the sequelae of childhood sexual abuse: A theoretical and empirical review. *Clinical Psychology Review, 21,* 1-32.

Burrows, G. C., Cox, T., & Simpson, G. C. (1977). The measurement of stress in a sales training situation. *Journal of Occupational Psychology, 50,* 45-51.

Bylund, C. L. & Makoul, G. (2002). Empathic communication and gender in the physician-patient encounter. *Patient Education and Counseling, 48*, 207-216.

Campbell, R., Ahrens, C., Wasco, S., Sefl, T., Barnes, H. (2001). Social reactions to rape victims: Healing and hurtful effects on psychological and physical health outcomes. *Violence and Victims, 16,* 287-302.

Coker, A. L., Smith, P. H., Thompson, M. P., McKeown, R. E., Bethea, L., & Davis, K. E. (2002). Social support protects against the negative effects of partner violence on mental health. *Journal of Women's Health & Gender-Based Medicine, 11(5)*, 465-476.

Consedine, N. S, Sabag-Cohen, S., & Krivoshekova, Y. S. (2007). Ethnic, gender, and socioeconomic differences in young adults' self-disclosure: who discloses what and to whom? *Cultural Diversity & Ethnic Minority Psychology, 13,* 254-263.

Cordova, M. J., Ruzek, J. I., Benoit, M. & Brunet, A. (2003). Promotion of emotional disclosure following illness and injury: A brief intervention for medical patients and their families. *Cognitive and Behavioral Practice, 10,* 358-371.

Coulehan, J. L., Platt, F. W., Egener, B., Frankel, R., Lin, C., Lown, B., Salazar, W. H. (2001) Let me see if I have this right…:Words that help build empathy. *Annals of Internal Medicine, 135,* 221-7.

Cutrona, C. E. (1986). Behavioral manifestations of social support: a microanalytic investigation. *Journal of Personality and Social Psychology, 51,* 201-208.

DePrince, A. P. (2001). Trauma and posttraumatic responses: An examination of fear and betrayal (Doctoral dissertation, University of Oregon, 2001). *Dissertation Abstracts International, 62,* 2953.

Dindia, K., & Allen, M. (1992). Sex differences in self-disclosure: A meta-analysis. *Psychological Bulletin, 112,* 106–124.

Dindia, K., Fitzpatrick, M., & Kenny, D. A. (1997). Self-disclosure in spouse and stranger interaction: A social relations analysis. *Human Communication Research, 23,* 388-412.

Elliott, R., Barker, C. B., Caskey, N., & Pistrang, N. (1982). *Journal of Counseling Psychology, 29,* 354-361.

Elliott, D.M., & Briere, J. (1992). Sexual abuse trauma among professional women: Validating the Trauma Symptom Checklist-40 (TSC-40). *Child Abuse & Neglect: The International Journal, 16,* 391-398.

Fassaert, T., van Dulmen, S., Schellevis, F., Bensing, J. (2007). Active listening in medical consultations: Development of the Active Listening Observation Scale (ALOS-global). *Patient Education and Counseling, 68,* 258-264.

Figueiredo, M. I., Fries, E., & Ingram, K. M. (2004). The role of disclosure patterns and unsupportive social interactions in the well-being of breast cancer patients. *Psycho-Oncology, 13*(2), 96-105.

Fischer, D. G., & Donatelli, M. J. (1987). A Measure of Stress and Arousal: Factor Structure of the Stress Adjective Checklist. *Educational and Psychological Measurement, 47*(2), 425.

Fisher, B., Daigle, L., Cullen, F., & Turner, M. (2003). Reporting sexual victimization to the police and others: Results from a national-level study of college women. *Criminal Justice and Behavior, 30,* 6-38.

Foa, E. B., Molnar, C., & Cashman L. (1995). Change in rape narratives during exposure therapy for Posttraumatic Stress Disorder. *Journal of Traumatic Stress, 8,* 675-690.

Fogarty, L. A., Curbow, B. A., Wingard, J. R., McDonnell, K., & Somerfield., M. R., (1999). Fogarty Can 40 seconds of compassion reduce patient anxiety? *Journal of Clinical Oncology, 17,* 371-379.

Fontes, L.A. (1993). Disclosures of sexual abuse by Puerto Rican children: Oppression and cultural barriers. *Journal of Child Sexual Abuse, 2,* 21-35.

Forrester, D., Kershaw, S., Moss, H., & Hughes, L.(2008). Communication skills in child protection: how do social workers talk to parents? *Child & Family Social Work, 13,* 41-51.

Foynes, M. M., Freyd, J. J., & Deprince, A. P. (2009). Child abuse, betrayal and disclosure. *Child Abuse & Neglect, 33,* 209-217.

Frankel, R. M. & Stein, T. (1999). Getting the most out of the client encounter: The Four Habits Model. *Journal of Medical Practice Management, 16,* 184-191.

Freyd, J. J. (1996). *Betrayal trauma: The logic of forgetting childhood abuse.* Cambridge, MA: Harvard University Press.

Freyd, J. J., DePrince, A. P., & Zurbriggen, E. L. (2001) Self-reported memory for abuse depends upon victim-perpetrator relationship. *Journal of Trauma & Dissociation, 2*(3), 5-16.

Freyd, J. J., Klest, B. & Allard, C. B. (2005). Betrayal trauma: Relationship to physical health, psychological distress, and a written disclosure intervention. *Journal of Trauma & Dissociation, 6(3),* 83-104.

Fritz, H. L., Nagurney, A. J., & Helgeson, V. S. (2003). Social interactions and cardiovascular reactivity during problem disclosure among friends. *Personality and Social Psychology Bulletin, 29,* 713-725.

Genero, N. P., Miller, J. B., Surrey, J., & Baldwin, L. M. (1992). Measuring perceived mutuality in close relationships: Validation of the Mutual Psychological Development Questionnaire, *Journal of Family Psychology, 6,* 36-48.

Gielen, A. C., Fogarty, L, O'Campo, P., Anderson, J., Keller, J., & Faden, R. (2000). Women living with HIV: Disclosure, violence, and social support. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 77,* 480-491.

Gleaves, D. H. & Eberenz, K. P. (1995). Assessing dissociative symptoms in eating disordered patients: Construct validation of two self report measures. *International Journal of Eating Disorders, 18,* 99-102.

Gleaves, D. H., Williams, T. L., Harrison, K., & Cororve, M. N. (2000). Measuring dissociative experiences in a college population: A study of convergent and discriminant validity. *Journal of Trauma & Dissociation, 1,* 43-57.

Gold, J. W. & Cardeña, E. (1998). Convergent validity of three posttraumatic symptoms inventories among adult sexual abuse survivors. *Journal of Traumatic Stress, 11,* 173-180.

Gold, S.R., Milan, L.D., Mayall, A., & Johnson, A.E. (1994). A cross validation of the trauma symptom checklist: The role of mediating variables. *Journal of Interpersonal Violence, 9,* 12-26.

Goldberg, LR. & Freyd, J.J. (2006). Self-reports of potentially traumatic experiences in an adult community sample: Gender differences and test-retest stabilities of the items in a Brief Betrayal-Trauma Survey. *Journal of Trauma & Dissociation, 7(3),* 39-63.

Green, B. L., Goodman, L. A., Krupnick, J. L., Corcoran, C. B., Petty, R. M., Stockton, P., & Stern, N. M. (2000). Outcomes of single versus multiple trauma exposure in a screening sample. *Journal of Traumatic Stress, 13,* 271-286

Haase, R. F., & Tepper, D. T. (1972). Nonverbal components of empathic communication. *Journal of Counseling Psychology, 19,* 417-424.

Halpern, J. (2003). What is clinical empathy? *Journal of General Internal Medicine, 18,* 670-674.

Hansen, F. C., Resnick, H., Galea, J. (2002). Better listening: Paraphrasing and perception checking—A study of the effectiveness of a multimedia skills training program. *Journal of Technology in Human Services, 20,* 317-331.

Hatcher, S. L., Nadeau, M. S., Walsh, L. K., Reynolds, M., Galea, J., & Marz, K. (1994). The teaching of empathy for high school and college students: Testing Rogerian methods with the Interpersonal Reactivity Index. *Adolescence, 29,* 961-974.

Heaven, P. & Ciarrochi, J. (2007). Personality and religious values among adolescents: A three wave longitudinal analysis. *British Journal of Psychology, 98,* 681-694.

Hemenover, S. H. (2003). The good, the bad, and the healthy: Impacts of emotional disclosure of trauma on resilient self-concept and psychological distress. *Personality & Social Psychology Bulletin, 29(10),* 1236-1244.

Hogan, B. E., Linden, W., Najarian, B. (2002). Social support interventions: Do they work? *Clinical Psychology Review, 22,* 381-440.

Hussong, A. M. & Hicks, R. E. (2003). Affect and peer context interactively impact adolescent substance use. *Journal of Abnormal Child Psychology, 31,* 413-426.

Imhof, M. (1998). What makes a good listener? Listener behavior in instructional settings. *International Journal of Listening, 12,* 81-105.

Ingram, K. M., Betz, N. E., Mindes, E. J., Schmitt, M. M., & Smith, N. G. (2001). Unsupportive responses from others concerning a stressful life event: Development of The Unsupportive Social Interactions Inventory. *Journal of Social and Clinical Psychology, 20(2),* 173-207.

Ingram, K. M., Jones, D. A., Fass, R. J., Neidig, J. L., & Song, Y. S. (1999). Social support and unsupportive social interactions: their association with depression among people living with HIV. *AIDS Care, 11(3),* 313-329.

Janusik, L. (2008). Introduction to listening in context: A special edition of The International Journal of Listening. *International Journal of Listening, 22,* 99-102.

Judd, J. M., McClelland, G. H., & Ryan, C. S. (2009). Models with continuous and categorical predictors: ANOVA. In *Data analysis: A model comparison approach* (pp. 219-246). New York, NY: Routledge.

King, M. G., Burrows, G. D., & Stanley, G. V. (1983). Measurement of stress and arousal: validation of the stress/arousal adjective checklist. *British journal of psychology, 74*(4), 473-479.

Klest, B. K. & Freyd, J.J. (2007). Global Ratings of Essays About Trauma: Development of the GREAT Code, and Correlations with Physical and Mental Health Outcomes. *Journal of Psychological Trauma, 6*(1), 1-20.

Kenny, D. A., Kashy, D. A., & Cook, W. L. (2006). *Dyadic data analysis.* New York, NY: Guilford.

Kogan, S. M. (2004). Disclosing unwanted sexual experiences: results from a national sample of adolescent women. *Child Abuse & Neglect, 28,* 147-165.

Lantz, P. M., House, J.S., Mero, R. P., & Williams, D. R. (2005). Stress, life events, and socioeconomic disparities in health: Results from the Americans' Changing Lives Study. *Journal of Health and Social Behavior, 46,* 274-288.

Lawson, M., & Winkelman, C. (2003). The social desirability factor in the measurement of listening skills: A brief report. *Counselling Psychology Quarterly, 16,* 43-45.

Leaper, C., Carson, M., Baker, C., Holliday, H., & Myers, S. (1995). Self-disclosure and listener verbal support in same-gender and cross-gender friends' conversations. *Sex Roles, 33,* 387-404.

Leonard, E. D. (1996). A social exchange explanation for the Child Sexual Abuse Accommodation Syndrome. *Journal of Interpersonal Violence, 11,* 107-117.

Lepore, S. J., Silver, C. B., Wortman, R. C., & Wayment, H. A. (1996). Social constraints, intrusive thoughts, and depressive symptoms among bereaved mothers. *Journal of Personality and Social Psychology, 70,* 271-282.

Lepore, S. J., Fernandez-Berrocal, P., Ragan, J., & Ramos, N. (2004). It's not that bad: Social challenges to emotional disclosure enhance adjustment to stress. *Anxiety, Stress, and Coping, 17,* 341-361.

Lepore, S. J., Ragan, J. D., & Jones, S. (2000). Talking facilitates cognitive-emotional processes of adaptation to an acute stressor. *Journal of Personality & Social Psychology, 78(3),* 499-508.

Lewis, J. A., Manne, S. L., DuHamel, K. N., Vicksburg, S. M., Bovbjerg, D. H., Currie, V., Winkel, G., & Redd, W. H. (2001). Social support, intrusive thoughts, and quality of life in breast cancer survivors. *Journal of Behavioral Medicine, 24(3),* 231-245.

Liang, B. Tracy, A., Taylor, C. A., Williams, L. M., Jordan, J. V., Miller, J. B. (2002). The Relational Health Indices: A study of women's relationships. *Psychology of Women Quarterly, 26,* 25-35.

Lisak, D., Conklin, A., Hopper, J., Miller, P. M., Altschuler, L., & Smith, B. M. (2000). The Abuse-Perpetration Inventory: Development of a valid assessment instrument for research on the cycle of violence. *Family Violence & Sexual Assault Bulletin, 16,* 21–30.

Lutgendorf, S. K. & Antoni, M. H. (1999). Emotional and cognitive processing in a trauma disclosure paradigm. *Cognitive Therapy and Research, 23,* 423-440.

Mackay, C., Cox, T., Burrows, G., & Lazzerini, T. (1978). An inventory for the measurement of self-reported stress and arousal. *British Journal of Social and Clinical Psychology, 17*(3), 283-284.

Mager, W. M., & Andrykowski, M. A. (2002). Communication in the cancer "bad news" consultation: Patient perceptions and psychological adjustment. *Psycho-Oncology, 11,* 35-46.

Major, B., Cozzarelli, C., Sciacchitano, A. M., Cooper, M., & Testa, M. (1990). Perceived social support, self-efficacy, and adjustment to abortion. *Journal of Personality & Social Psychology, 59(3),* 452-463.

Mindes, E. J., Ingram, K. M., Kliewer, W., & James, C. A. (2003). Longitudinal analyses of the relationship between unsupportive social interactions and psychological adjustment among women with fertility problems. *Social Science & Medicine, 56(10),* 2165-2180.

New Jersey Self-Help Group Clearinghouse. (n.d.). Improving your listening skills. In New Jersey Self-Help Group Clearinghouse library of downloadable "how-to" group literature. Retrieved March 28, 2009, from http://www.njgroups.org/.

Paine, M. L., & Hansen, D. J. (2002). Factors influencing children to self-disclose sexual abuse. *Clinical Psychology Review, 22*(2), 271-295.

Parker, R. G. & Parrot, R. (1995). Patterns of self-disclosure across social support networks: elderly, middle-aged, and young adults. *International Journal of Aging & Human Development, 41,* 281-297.

Pennebaker, J.W., & Chung, C.K. (2007). Expressive writing, emotional upheavals, and health. In H. Friedman and R. Silver (Eds.), *Handbook of health psychology* (pp. 263-284). New York: Oxford University Press.

Pierce, G. R., Sarason, I. G., Sarason, B. R., Solky-Butzel, J. A., & Nagel, L. C. (1997). Assessing the quality of personal relationships. *Journal of Social and Personal Relationships, 14*, 337-353.

Pine, D. S. & Cohen, J. A. (2002).Trauma in children and adolescents: Risk and treatment of psychiatric sequelae. *Society of Biological Psychiatry, 51,* 519-531.

Pistrang, N., Barker, C., & Rutter, C. (1997). Social support as conversation: Analysing breast cancer patients' interactions with their partners. *Social Science & Medicine, 45,* 773-782.

Pistrang, N., Solomons, W., & Barker, C. (1999). Peer support for women with breast cancer: The role of empathy and self-disclosure. *Journal of Community & Applied Social Psychology, 9,* 217-229.

Pollak, K. I., Arnold, R. M., Jeffreys, A. S., Alexander, S. C., Olsen, M. K., Abernethy, A. P., Skinner, C. S., Rodriguez, K. L., Tulsky, J. A. (2007). Oncologist communication about emotion during visits with patients with advanced cancer. *Journal of Clinical Oncology, 25,* 5748-5752.

Rautalinko, E. & Lipser, H. (2004). Effects of training reflective listening in a corporate setting. *Journal of Business & Psychology, 18,* 281-299.

Resnick, H. (1998). Paraphrase II: A listening skills training program for human services students. *Computers in Human Services, 15,* 89-96.

Riggs, D. S., Cahill, S. P., & Foa, E. B. (2006). Prolonged Exposure Treatment of Posttraumatic Stress Disorder. In V.M Follette & J. I. Ruzek (Eds), *Cognitive Behavioral Therapies for Trauma* (pp. 65-95). New York, New York: The Guilford Press.

Rime, B. (1995). Mental rumination, social sharing, and the recovery from emotional exposure. In J. W. Pennebaker (Ed.), *Emotion, Disclosure, & Health* (pp. 271-292). Washington, DC: American Psychological Association.

Robertson, K. (2005). Active listening – more than just paying attention. *Australian Family Physician, 34,* 1053-55.

Rosenberg, M. (1965). *Society and the adolescent self-image.* Princeton, NJ: Princeton University Presss.

Ruggiero, K. J., Smith, D. W., Hanson, R. F., Resnick, H. S., Saunders, B. E., Kilpatrick, D. G., Best, C. L. (2004). Is disclosure of childhood rape associated with mental health outcome? Results from the National Women's Study. *Child Maltreatment:*

Journal of the American Professional Society on the Abuse of Children, 9(1), 62-77.

Russell, D., Peplau, L. A., & Cutrona, C. E. (1980). The revised UCLA Loneliness Scale: Concurrent and discriminant validity evidence. *Journal of Personality and Social Psychology, 39,* 472-280.

Ryan, R.M. & Solky, J.A. (1996). What is supportive about social support? On the psychological needs for autonomy and relatedness. In G.R. Pierce, B. R. Sarason, & I.G. Sarason (Eds.), *Handbook of Social Support and the Family,* (pp. 249-267). New York, NY: Plenum Press.

Smith, D. W., Letourneau, E. J., Saunders, B. E., Kilpatrick, D. G., Resnick, H. S., & Best, C. L. (2000). Delay in disclosure of childhood rape: Results from a national survey. *Child Abuse & Neglect, 24*(2), 273-287.

Smith, N. G., & Ingram, K. M. (2004). Workplace Heterosexism and Adjustment Among Lesbian, Gay, and Bisexual Individuals: The Role of Unsupportive Social Interactions. *Journal of Counseling Psychology, 51,* 57-67.

Smith, R. C., & Hoppe, R. B. (1991). The patient's story: Integrating the patient- and physician-centered approaches to interviewing. *Annals of Internal Medicine, 115,* 470-477.

Somer, E., & Szwarcberg, S. (2001). Variables in delayed disclosure of childhood sexual abuse. *American Journal of Orthopsychiatry, 71,* 332–341.

Sorsoli, L. (2007). Where the whole thing fell apart: Race, resilience, and the complexity of trauma. Journal of Aggression, Maltreatment & Trauma, 14, 99-121.

Sweetland, J. (n.d.). Nonverbal Evaluation Form for Cooperative Lesson. In Microteaching Evaluation and Reflection Directory. Retrieved October 29, 2008, from http://www.homeofbob.com/pedagogy/teach/reflectnAndAs/microteach/evaluation/nonvrblCoopLsnFrm.html.

Taheri S. (2006). The link between short sleep duration and obesity: We should recommend more sleep to present obesity. *Archives of Disease in Childhood, 91,* 881–884.

Taylor, L. K., Cook, P. F., Green, E. E., & Rogers, J. K. (2001). Better interviews: The effects of supervisor training on listening and collaborative skills. *Jounral of Educational Research, 82,* 89-95.

Thorpy, M. J. & Yager, J. (2001). *The encyclopedia of sleep and sleep disorders* (2nd ed.). New York: Facts on File, Inc.

Tyagi, S. V. (2002). Incest and women of color: A study of experiences and disclosure. Journal of Child Sexual Abuse, 10(2), 17-39.

Ullman, S. E. (2007). Relationship to perpetrator, disclosure, social reactions, and PTSD symptoms in child sexual abuse survivors. *Journal of Child Sexual Abuse, 16,* 19 36.

Ullman, S. E. (2000). Psychometric characteristics of the Social Reactions Questionnaire: A measure of reactions to sexual assault victims. *Psychology of Women Quarterly, 23,* 257-270.

Ullman, S. (1996). Do social reactions to sexual assault victims vary by support provider? *Violence and Victims, 11,* 143-156.

Ullman, S. & Filipas, H. (2005). Ethnicity and child sexual abuse experiences of female college students. *Journal of Child Sexual Abuse, 14,* 67-89.

Ullman, S. Filipas, H. (2001). Correlates of formal and informal support seeking in sexual assault victims. *Journal of Interpersonal Violence, 16,* 1028-1047.

U.S. Department of Health and Human Services. (1996). *Physical activity and health: A report of the Surgeon General.* Atlanta, Georgia: US Department of Health and Human Services, Public Health Service, CDC, National Center for Chronic Disease Prevention and Health Promotion.

U.S. Department of Health and Human Services and U.S. Department of Agriculture. (2005). *Dietary Guidelines for Americans* (6th ed.). Washington, DC: U.S. Government Printing Office.

Watson, D. & Clark, L. A. (1994). Measurement and mismeasurement of mood: Recurrent and emergent issues. *Journal of Personality Assessment, 68,* 267-296.

Yager, J., & Thorpy, M. J. (2001). *Sleeping Well: The Sourcebook for Sleep and Sleep Disorders.* New York: Facts on File, Inc.

Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K., (1988). The multidimensional scale of perceived social support. *Journal of Personality Assessment, 52,* 30-41.

Zlotnick, C., & Shea, M. T. (1996). The validation of the Trauma Symptom Checklist-40(TSC-40) in a sample of inpatients. *Child Abuse & Neglect, 20,* 503-510.