DISSERTATION

THERAPIST RESPONSES TO CHILDHOOD SEXUAL ABUSE DISCLOSURES

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ABSTRACT

THERAPIST RESPONSES TO CHILDHOOD SEXUAL ABUSE DISCLOSURES

The present study investigated possible differences in how male and female therapists respond to a disclosure of childhood sexual abuse (CSA) from a male or female client. A total of $N = 249$ practicing psychologists read a vignette describing a disclosure of CSA by a client. Participants were then asked to complete quantitative and qualitative measures on disclosure responses, attitudes toward survivors of CSA, and socially desirable response patterns. Multivariate analyses indicated that, after accounting for attitudes toward survivors of CSA, male and female therapists did not significantly differ on their responses to a CSA disclosure, and that male and female clients did not elicit significantly different responses. Data from the present study was compared with that of a previous study on college student responses to CSA disclosures. These post-hoc analyses revealed that college students were more likely than therapists to provide emotionally supportive, distracting, and egocentric responses to a CSA disclosure. Analyses also revealed that therapists endorsed significantly more negative attitudes toward survivors of CSA than college students. Implications for clinical practice and future directions for research are discussed.

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CHAPTER 1: INTRODUCTION

Recent estimates reported approximately 64,000 substantiated cases of childhood sexual abuse (CSA) occurred in one year alone in the United States of America (U.S. Department of Health and Human Services, 2011). Other sources utilizing retrospective reporting have estimated lifetime prevalence rates of CSA to be as high as 12.8% for females and 4.3% for males (MacMillan et al., 1997). Although complications related to reporting and measuring CSA have precluded our ability to obtain exact prevalence rates, CSA is widely recognized by clinicians and researchers as a pervasive problem and as having lasting effects on later social and psychological development (Briere & Elliot, 2003).

As pervasive as CSA is, many survivors of CSA grow to learn that their experiences are best kept a secret (Anderson, Martin, Mullen, Romans, & Herbison, 1993; Frenken & Van Stolk, 1990; McMillen & Zuravin, 1998; McNulty & Wardle, 1994; Ullman, 2003; Wyatt, Loeb, Solis, Carmona, & Romero, 1999). At the same time, the telling of this secret, the disclosing of CSA, has been widely regarded as an integral part of the healing process for survivors of maltreatment (Reviere, 1996). As such, the dynamics of abuse disclosures have increasingly come to the attention of researchers. Much of the abuse disclosure literature has focused on whether or not disclosing abuse is beneficial, with studies yielding mixed results (see Ullman, 2003 for a review). One important conclusion that may be drawn from the disclosure literature is that it is not necessarily the act of telling, but rather how others respond, that can be healing in some cases and hurtful in others (Harvey, Orbuch, Chwalisz, & Garwood, 1991; McNulty & Wardle, 1994; Ullman & Filipas, 2005).

Disclosure response factors have been examined from the perspective of the victim, with victims of CSA reporting that the most helpful reactions to a disclosure were responses such as

being believed and being offered tangible aid and support, while the least helpful responses were being blamed, treated differently, controlled, and encouraged to keep the CSA a secret (Ullman, 2000). However, until recently, few studies have systematically examined how others might actually respond when faced with a disclosure of CSA. One important group of respondents to disclosures of CSA is therapists, as disclosure has been widely accepted as an integral part of the recovery process for survivors of abuse (Reviere, 1996). Contrary to this, though, survivors of CSA have been found to be reluctant to disclose CSA experiences to a therapist as they fear receiving negative reactions from the therapist (McMillen & Zuravin, 1998; McNulty & Wardle, 1994; Ullman, 2003). An exploration into how therapists respond to disclosures of CSA may inform our understanding of the factors related to providing more or less helpful responses in therapy and may inform the development of appropriate training modules for therapists. Additionally, responses to CSA disclosures may be seen as a proxy for attitudes about survivors of CSA, reflective of social attitudes and biases regarding survivors of CSA. It is of clinical relevance to note that the endorsement of positive and negative attitudes toward survivors of CSA by therapists has been found to significantly affect the treatment offered to survivors (Knight, 1997). An understanding of the processes involved in how therapists respond to CSA disclosures has the potential of being highly informative in the treatment of survivors of CSA.

CHAPTER 2: LITERATURE REVIEW

Believability and Credibility of CSA Disclosures

Perhaps as a reaction to the controversial issue of repressed memories and their inaccuracy (Reviere, 1996), much of the research on perceptions of CSA has focused on the believability and credibility of disclosures. Indeed, being believed has been rated by adult survivors of sexual assault as one of the most helpful and supportive reactions to a disclosure (Ullman, 2000). An exploration of the factors involved in the perceived credibility of a disclosure may provide for a better understanding of why some disclosures of CSA are met with more support than others.

One important factor in believing a CSA disclosure may be the gender of the recipient of that disclosure. Specifically, multiple studies have found that male respondents were less likely than female respondents to believe a report of CSA from a survivor (e.g., Bornstein, Kaplan, & Perry, 2007; Bottoms & Goodman, 1994; Cromer & Freyd, 2007; McCoy & Gray, 2007; Quas, Bottoms, Haegerich, & Nysse-Carris, 2002; Rogers & Davies, 2007). One possible explanation for this difference may lie in how males and females perceive cases of CSA. Bornstein et al. (2007) found that male and female mock jurors significantly differed in their ratings of severity when evaluating a case of CSA, with females rating the case as more severe than males. This difference in how CSA is viewed by males and females may impact the determination of whether or not a crime was committed in a particular case, and whether or not the victim's account should be taken seriously (Hetherton & Beardsall, 1988). Additionally, the differences in how males and females judge the credibility of CSA cases may be related to attitudes toward survivors of CSA. Rodriguez-Srednicki and Twaite (1999) found that males were more likely than females to hold negative attitudes toward survivors of CSA, including being more likely to evaluate

survivors of CSA as "dishonest," "guilty," and "immoral." It may follow that these attitudes moderate the relationship between respondent gender and the perceived credibility of a CSA disclosure.

Although the gender of the respondent has been shown to be related to differences in perceptions of credibility of CSA disclosures, manipulating the gender of the victim has not been consistently shown to lead to differences in perceptions of credibility. That is, the accounts of male survivors of CSA have been judged to be as credible as that of female survivors (Bornstein et al., 2007; Quas et al., 2002; Rogers & Davies, 2007), although this has not been found to be the case in female-perpetrated sexual abuse (Hetherton & Beardsall, 1988).

Although research has explored many factors related to the perceived credibility of CSA disclosures, much of this research has focused on disclosures from children and in courtroom settings. Few studies have examined the believability of adult disclosures of CSA and disclosures that occur outside of the courtroom, such as within friend relationships. Ullman and Filipas (2005) took such an approach, finding that female college students reported receiving more positive social reactions, including belief and validation, than male college students following a CSA disclosure. Other studies comparing child and adult disclosures of CSA have found that victims have rated disclosures occurring in adulthood as being met with more positive social reactions and as being more helpful than disclosures that occurred in childhood (Lamb & Edgar-Smith, 1994; Roesler & Wind, 1994). However, such studies have relied on retrospective reporting from victims to draw conclusions about how others might respond. In directly assessing respondents' reactions to a hypothetical disclosure of CSA in an adult friend relationship, Karwan (2009) found that female college students tended to give more positive responses, such as believing the victim, than male college students. However, varying the

gender of the victim described in the hypothetical disclosure scenario did not lead to significant differences in helpful or hurtful responses received.

Attribution of Blame in CSA Cases

As being believed has been found to be one of the most helpful responses to a CSA disclosure, being blamed for the abuse has been rated by adult survivors of CSA as one of the most hurtful responses (Ullman, 2000). Thus, the factors involved in how others attribute blame in cases of CSA may further inform our understanding of what might lead to a less helpful response to a CSA disclosure.

Research on the factors related to the attribution of blame in cases of CSA has yielded mixed results. One factor that has been investigated is the gender of the respondent making the judgment of blame in a case of sexual assault. Some studies have shown male respondents to attribute more responsibility than female respondents to child survivors of CSA (Back & Lips, 1998) and adult survivors of sexual assault (Mitchell, Hirschman, & Hall, 1999; Smith, Pine, & Hawley, 1988), whereas other studies have shown no significant differences in male and female respondents' attributions of blame (Broussard & Wagner, 1988; Richey-Suttles & Remer, 1997).

Another factor that has been studied in the attribution of blame literature and has likewise yielded mixed results has been the gender of the victim. In studying how college students attribute blame in cases of CSA, Back and Lips (1998) found no significant differences in the amount of blame attributed to male and female victims. Similarly, Broussard and Wagner (1988) manipulated the child victim's behavior to be more or less resisting of the abuse and found that raters did not significantly differ in their attributions of responsibility to male and female victims across resistance conditions. Although the literature on the attribution of blame has not shown significant differences in how much blame is placed on male and female children who have been

sexually abused, other studies suggest that adult male and female survivors of sexual assault may elicit different attributions of blame from others (Perrot & Webber, 1996; Smith et al., 1988). Perrot and Weber (1996) found that stories of adult male and female survivors of sexual assault were faced with different types of blame, with male survivors being more likely to be blamed for not physically defending against the attackers, and female survivors being more likely to be blamed for being too trusting of the attackers. It is possible that these differences may be explained by differences in gender role attitudes. Richey-Suttles and Remer (1997) found that more strict gender role attitudes were predictive of blaming adult survivors of CSA. However, as the researchers only studied male survivors, it remains unclear how male and female survivors differ on being blamed as a function of gender role attitudes.

Much of the research on the attribution of blame in CSA cases has been done with child and adolescent victims, with little attention paid to adult survivors. However, studies of child victims that have manipulated the age of the victim have found that the older the child, the higher the probability of receiving blame for the abuse (Back & Lips, 1998; Waterman & Foss-Goodman, 1984). Thus, one might expect that stories of adult survivors of CSA would be met with more victim blame than stories of child victims. However, it remains unclear whether these differences in blame by victim age are due to the victim being older when disclosing the abuse, or due to the victim being older at the time of the abuse. Indeed, when asked directly, adult survivors of CSA have reported their disclosures to be met with blame (Ullman, 2000). Systematically testing the reactions of those responding to a disclosure from an adult survivor of CSA may provide for a greater understanding of this dynamic.

Clinical Implications

As the deleterious effects of receiving a negative reaction to a disclosure of CSA have been thoroughly investigated and established in the literature (see Ullman, 2003 for a review), it seems of the utmost importance that mental health professionals avoid these negative reactions in their work with survivors of CSA. As vulnerable as a disclosure of CSA inherently is, the therapeutic relationship may provide an additional layer of vulnerability and susceptibility to the negative effects of receiving a hurtful response to a CSA disclosure.

Sano, Kobayashi, and Nomura (2003) illustrated these possible negative effects in an in-depth review of 12 cases of women who had voluntarily disclosed CSA in a therapy setting. In six of the 12 cases, the therapeutic relationship was considered to be significantly disrupted following the disclosure of CSA. Negative outcomes included severe transference around the traumatic event, delusional thinking, regression, dissociation, and premature termination of therapy. The authors strongly advocated for the use of support from other therapists and individual supervision in helping to manage and reduce these negative outcomes. However, although data on client factors and therapy progress was analyzed, the researchers did not examine therapist-related factors, such as the therapists' reactions and affective responses to the disclosures. It is possible that these factors may have contributed to the differences in cases that resulted in negative outcomes.

Therapists' affective reactions have been examined elsewhere (e.g., Faller, 1993; Gardner, 2008; Knight, 1997). Beyond describing the common feelings of helplessness, anger, and distrust, as well as experiencing rescue fantasies and desires for victim retribution following a CSA disclosure, Knight (1997) examined how these therapist reactions and attitudes may affect the treatment received by survivors of CSA. It was found that feelings of anger from the

therapist following a disclosure of CSA were related to the therapist 'tuning out' in session, avoiding the discussion of painful topics, not believing the client's disclosure, and countertransference issues. Thus, therapists' reactions to disclosures of CSA may have serious implications on the welfare of clients. Indeed, in a study of female survivors of CSA in the Netherlands, 60% reported being disappointed with the overall experiences they had with mental health professionals, reporting that more than a third of the therapists they had seen reacted to their disclosures of CSA with disbelief, victim-blaming, belittling, and/or minimizing responses (Frenken & Van Stolk, 1990). An understanding of the factors involved in these negative therapist reactions and harmful therapy experiences certainly has implications in providing the best quality of care to survivors of CSA.

Purpose of the Present Study

The purpose of the present study was to investigate how therapists would react and respond to disclosures of CSA within the context of a therapeutic relationship. Specifically, the present study examined how male and female psychologists responded to a disclosure of CSA by a male or female client during the course of long-term treatment. The present study focused exclusively on disclosures of CSA involving a male perpetrator, as male-perpetrated CSA has been estimated to account for over 95% of identified or reported cases of CSA (Grayston & De Luca, 1999). Furthermore, the present study focused exclusively on disclosures of CSA involving a perpetrator known by the victim, as opposed to CSA perpetrated by a stranger, as the majority of identified cases of CSA are perpetrated by someone with whom the victim has some prior relationship, such as an extended family member (Finkelhor, 1984; Holmes & Slap, 1998; U.S. Department of Health and Human Services, 2011).

Based on the relevant literature, it was hypothesized that female therapists responding to a disclosure of CSA would be more likely than male therapists to endorse responses that have been rated as more helpful by victims of CSA (Ullman, 2000), including offering emotional support, believing the victim, and providing tangible aid and information. Furthermore, it was hypothesized that male therapists responding to a disclosure of CSA would be more likely than female therapists to endorse responses that have been rated as less helpful by victims of CSA, including egocentric and distracting responses. These relationships between therapist gender and positive or negative disclosure responses were hypothesized to hold after accounting for attitudes toward survivors of CSA.

As the literature has been mixed regarding whether or not male and female survivors elicit different reactions when disclosing CSA, no specific hypotheses were made in the proposed study regarding possible differences in reactions to CSA disclosures from male and female clients. However, responses to male and female client disclosures and possible interactions between therapist gender and client gender in disclosure responses were examined in an exploratory fashion. Also examined in an exploratory fashion were qualitative responses to disclosures of CSA for the purpose of further informing the quantitative data.

CHAPTER 3: METHOD

Participants

Psychologists engaged in psychotherapy served as participants in the present study. Initially, the participant pool was comprised of psychologists from university counseling centers throughout the United States of America. University counseling centers were included in the present study if they were registered through the Association of Psychology Postdoctoral and Internship Centers (APPIC) as being an internship site with a "Primary Agency Type" of "University Counseling Center" as of January 23, 2011. According to psychologist employment data reported by APPIC, this included a total of 1,064 psychologists from 131 university counseling centers who could have served as participants in the proposed study. Of these 1,064 psychologists, n = 73 psychologists responded to the e-mail recruitment letter to participate, yielding a 6.9% response rate.

Due to the small response rate and sample size, the participant pool was broadened to include psychologists registered in the American Psychological Association's Membership Directory. Search criteria for the online Membership Directory was as follows: Country: United States; Current Major Field: Couns[eling] Psych[ology]; Highest Degree: Doctor of Philosophy or Doctor of Psychology; Private Practice: Yes. This search strategy yielded a total of 1,362 results, of which 374 psychologists either did not have an e-mail address listed in the database, did not have a valid e-mail address, or opted out of having their contact information published in the directory. Of the remaining 988 psychologists who were sent an e-mail recruitment letter, n = 176 psychologists participated in the present study, yielding a 17.8% response rate, and comprising a total sample size of N = 249 participants.

The participants in the present study consisted of 73 males (29.3%) and 171 females (68.7%), with five participants (2.0%) not reporting gender. The average age of the sample was *M* = 51.8 years (*SD* = 12.8 years). Average ages by gender were comparable, with an average age for males of *M* = 54.9 years (*SD* = 13.1 years), and an average age for females of *M* = 50.5 years (*SD* = 12.6 years). The sample consisted of 206 White non-Hispanic (82.7%), 14 African American (5.6%), nine Hispanic/Latino (3.6%), eight Asian or Pacific Islander (3.2%), three Middle Eastern (1.2%), and five biracial (2.0%) participants, with four participants (1.6%) not reporting ethnicity. The vast majority of participants (92.0%) reported having a Doctorate of Philosophy (*n* = 229), while 6.8% reported having a Doctorate of Psychology (*n* = 17), and 0.4% reported having a Doctorate of Education (*n* = 1), with 0.8% not reporting their highest degree held (*n* = 2). Reported years of experience as a psychologist ranged from 0 to 52 years (*M* = 18.6 years, *SD* = 11.3 years).

Measures

Demographic Information Form. Information on the participant's age, gender, ethnicity, degree, and years of clinical experience as a psychologist was gathered by self-report on a demographic information form (see Appendix A).

Childhood Sexual Abuse Disclosure Vignette. For the purpose of simulating a situation in which a therapist might receive a disclosure of childhood sexual abuse from a long-term individual therapy client, two versions of a vignette were written (see Appendix B). The vignettes differed only by the gender of the victim (i.e., "Karl"/"Karla") and by gender-descriptive pronouns (i.e., "he"/"she"). The vignettes described a situation in which a client discloses that they engaged in sexual acts at a young age with an uncle. The descriptions of the "sexual acts" were purposefully written in a vague manner and did not include any explicit

reference to force, intimidation, or coercion, as suggested by Rodriguez-Srednicki and Twaite (1999) to allow for more individual interpretation of the situation.

Open-ended Disclosure Response Item. Participants were asked to respond to the following prompt: "In the text box below, please write your response to the client's disclosure of childhood sexual abuse:" (see Appendix B). Participants were given unlimited space to write a response to the hypothetical disclosure of sexual abuse.

Sexual Abuse Disclosure Response Scale (SADRS), Modified. Developed from an unpublished thesis study (Karwan, 2009), the SADRS is a self-report measure of verbal and behavioral reactions to a hypothetical disclosure of childhood sexual abuse. The SADRS was developed as a revision and elaboration of the Social Reactions Questionnaire (SRQ; Ullman, 2000), which consists of items measuring seven domains of reactions: Emotional Support/Belief, Treat Differently, Distraction, Take Control, Tangible Aid/Information Support, Victim Blame, and Egocentric. Whereas the SRQ measures the reactions that sexual assault survivors receive when they disclose their experience, the development of the SADRS involved rephrasing SRQ items to measure how one might respond when receiving a disclosure of CSA. For example, the SRQ item "Told you it was not your fault" was rephrased for the SADRS as "Tell them it was not their fault." In addition, items reflecting possible verbal responses to a disclosure were developed by revising SRQ items into verbal response items from the perspective of the respondent to a disclosure of CSA (e.g., "It wasn't your fault."). Confirmatory factor analysis of the SADRS confirmed the presence of four of the seven factors: Emotional Support/Belief, Tangible Aid/Information Support, Distraction, and Egocentric (Karwan, 2009). The resulting SADRS included 55 items from four subscales.

As the SADRS was written from the perspective of a close friend, a modified version was developed for the present study to be more appropriate for use with therapists (see Appendix C). Four behavioral items and five verbal items were revised to be more reflective of therapeutic settings (e.g., "Spend time with them" was revised as "Go over the session hour if they need more time."). Participants were asked to respond to each of the 55 items on the basis of how likely they were to say or do each item following a client's disclosure of childhood sexual abuse. Participants responded to each item on a Likert-type scale from 1 to 5, with 1 indicating "Very Unlikely" and 5 indicating "Very Likely."

Bipolar Adjective Rating Scales (BARS). Developed by Rodriguez-Srednicki and Twaite (1999) by selecting adjective pairs relevant to perceptions of CSA, the BARS is a self-report measure which asks subjects to rate a survivor of CSA on each of 10 adjective pairs (see Appendix D). For each adjective pair, subjects were asked to use a seven-point response format to indicate the extent to which one adjective in the pair characterized the client described in the Childhood Sexual Abuse Disclosure Vignette better than the other adjective in the pair. The scale yields Assertiveness and Negative Evaluation Factor scale scores, based on a factor analysis of the adjective pairs. Rodriguez-Srednicki and Twaite found internal consistency reliabilities for the Assertiveness and Negative Evaluation Factor scales to be .86 and .78, respectively.

Self-Monitoring Scale (SMS), Other-Directedness factor. Developed by Snyder (1974), the Self-Monitoring Scale (SMS) is a self-report measure intended to assess the degree to which individuals monitor and control their behaviors on the basis of social or situational cues (see Appendix E). Subsequent factor analysis on the scale yielded three factors: Acting, Extraversion, and Other-Directedness (Briggs, Cheek, & Buss, 1980). For the purposes of the

present study, only the 11-item Other-Directedness factor was used. The Other-Directedness factor has been proposed by Briggs et al. to measure the extent to which an individual changes their behaviors and attitudes to be in accord with social pressures. Briggs et al. reported internal consistency reliabilities of the Other-Directedness factor to be .70 to .72 across two samples. As the SADRS may be sensitive to the effects of socially desirable responding, the Other-Directedness factor of the SMS was used in the present study to control for such effects.

Marlowe-Crowne Social Desirability Scale (M-C SDS). Developed by Crowne and Marlowe (1960), the M-C SDS is a self-report measure created to assess the extent to which subjects respond in a socially desirable manner (see Appendix F). Subjects were asked to indicate whether each of 33 items was true or false for them. The items are based on behaviors that have a low prevalence rate in the general population, yet are seen as socially desirable behaviors. Thus, a subject who endorses many such items may be assumed to be responding in a socially desirable manner that may not be representative of their actual behavior. Crowne and Marlowe reported an internal consistency reliability of .88 for the scale. The M-C SDS was used in the present study as an additional assessment of socially desirable responding.

Procedure

In the initial recruitment phase, participation in the present study was made available to psychologists through e-mail requests to training directors of university counseling centers, requesting that they forward information about the study to psychologists on staff at their university counseling center (see Appendices G, H, and I). The e-mails provided a link to an online survey service which allowed participants to respond to study materials anonymously. The e-mails also informed participants that for every response received, $1.00 would be donated to a national anti-sexual violence organization. Due to a low response rate, a subsequent

recruitment phase was employed with psychologists registered with the American Psychological Association. The e-mail recruitment letters for this participant pool were similar to the previously sent e-mail requests (see Appendices J and K).

Following the link in the e-mail, participants were brought to the first page of the online survey, which included an informed consent form (see Appendix L). Participants were asked to read the consent form and, should they choose to continue, click a link labeled "Next" signifying their receipt of the informed consent information and their voluntary participation in the study. Those who did so were presented with a series of web pages containing study materials in the following order: the Demographic Information Form, one randomly selected version of the Childhood Sexual Abuse Disclosure Vignette, the Open-ended Disclosure Response Item, the SADRS, the BARS, the SMS Other-Directedness factor, and the M-C SDS. Following completion of the study materials, participants were directed to an online version of a debriefing form (see Appendix M), which provided additional information on the specific purpose of the study.

CHAPTER 4: RESULTS

Quantitative Analyses

Prior to conducting analyses on group differences, psychometric properties of the SADRS were assessed as the instrument's reliability had not been established. Internal consistencies on the SADRS subscales were estimated using Cronbach's alpha reliability coefficients. The subscales were found to have acceptable internal consistency reliability estimates: Emotional Support/Belief ($\alpha = .90$), Tangible Aid/Information Support ($\alpha = .83$), Distraction ($\alpha = .74$), and Egocentric ($\alpha = .72$). The BARS and M-C SDS were also found to have acceptable reliability estimates in the present study: BARS Assertiveness ($\alpha = .82$), BARS Negative Evaluation Factor ($\alpha = .90$), and M-C SDS ($\alpha = .85$). The SMS Other-Directedness factor, however, was found to have a low estimated reliability in the present study ($\alpha = .51$), and was therefore not used as a validity indicator in subsequent analyses.

The SADRS subscales and individual items were correlated with the M-C SDS total score to assess for susceptibility to socially desirable responding. An a priori cutoff of $r = \pm.30$ was used to determine if SADRS subscales or individual items were too highly correlated with the M-C SDS total score to be included in subsequent analyses. Using this cutoff ensured that SADRS subscales and items had a correlation effect size to the M-C SDS that was less than "medium"-sized, as defined by Cohen (1992). The use of the M-C SDS to validate scales and items, rather than participant response sets, was suggested by McCrae and Costa (1983). When correlated with the M-C SDS, none of the SADRS subscales met the cutoff criterion: Emotional Support/Belief, $r(210) = .06$, $p = .392$, Tangible Aid/Information Support, $r(229) = .03$, $p = .657$, Distraction, $r(229) = .17$, $p = .010$, and Egocentric, $r(234) = -.04$, $p = .541$. Additionally, none of

the 55 individual SADRS items correlated with the M-C SDS at or above the a priori cutoff criterion (*r*s = -.16 to .21).

Correlations between conceptually similar SADRS subscales were generally as expected (see Table 1). As multiple comparisons were calculated, a Bonferroni correction was used to set the cutoff for statistical significance at $p < .008$ to maintain the familywise error rate. That is, the standard significance level ($\alpha = .05$) was divided by the number of planned comparisons ($n = 6$) to account for the increased probability of falsely rejecting the null hypothesis due to making multiple comparisons. As expected, the positive social reaction subscales (i.e., Emotional Support/Belief and Tangible Aid/Information Support) were found to be significantly positively correlated, $r(216) = .51$, $p < .001$. The negative social reaction subscales (i.e., Distraction and Egocentric) were significantly positively correlated as well, $r(236) = .42$, $p < .001$. Unexpectedly, neither of the positive social reaction subscales were significantly negatively correlated with either of the negative social reaction subscales. In fact, significant positive correlations, albeit low in magnitude, were found between SADRS Emotional Support/Belief and the negative social reaction subscales (Distraction, $r(212) = .29$, $p < .001$, Egocentric, $r(217) = .26$, $p < .001$). The correlation between SADRS Tangible Aid/Information Support and Egocentric was significant at the $p < .05$ level, but did not reach the a priori $p < .008$ cutoff for statistical significance, $r(238) = .14$, $p = .031$.

Correlations between SADRS subscales and BARS scale scores were calculated as well (see Table 2). Multiple comparisons again necessitated the use of a Bonferroni correction to maintain the familywise error rate. As $n = 4$ comparisons per BARS scale were planned, the standard significance level ($\alpha = .05$) was divided by this number of planned comparisons to set the cutoff for statistical significance at $p < .013$. As expected, SADRS Emotional Support/Belief

and Tangible Aid/Information Support were significantly negatively correlated with the BARS Negative Evaluation Factor (*r*s = -0.41 and -0.25, respectively, *p*s < .001). In addition, SADRS Emotional Support/Belief and Tangible Aid/Information Support were significantly positively correlated with BARS Assertiveness (*r*s = 0.29 and 0.32, respectively, *p*s < .001). However, unexpectedly, SADRS Distraction and Egocentric were not found to be significantly correlated with BARS Negative Evaluation Factor (*r*s = 0.07 and -0.04, respectively, *p*s > .01) or BARS Assertiveness (*r*s = -0.09 and 0.09, respectively, *p*s > .01).

To test the hypotheses of group differences in responses to disclosures of CSA, data was analyzed using two multiple analysis of covariance (MANCOVA) tests. The use of two separate analyses was indicated due to a lack of large and significant correlations between the proposed dependent variables, the SADRS subscales. Therefore, the first analysis included SADRS Emotional Support/Belief and Tangible Aid/Information Support as dependent variables, and the second analysis included SADRS Distraction and Egocentric as dependent variables. In both analyses, the gender of the therapist and gender of the client described in the vignette were entered into the model as independent variables. Scale scores on the BARS were analyzed as covariates in both analyses. Homogeneity of the covariance matrices, an assumption of the MANCOVA model, was tested using the Box's M test, whereby a significant test result is indicative of a lack of homogeneity of variance among the dependent variables.

In the first MANCOVA, in which SADRS Emotional Support/Belief and Tangible Aid/Information Support were entered as dependent variables (see Table 3), the Box's M test indicated the presence of homogeneity of the covariance matrices, Box's M = 5.82, $F(9, 103505) = 0.63$, $p = .770$. Wilks' Lambda coefficients were used to determine the significance of group differences on the dependent variables. The BARS Negative Evaluation Factor was found to be

a significant covariate, Wilks' $\Lambda = .92$, $F(2, 202) = 9.05$, $p < .001$. BARS Assertiveness was not found to be a significant covariate in the analysis, although it approached significance, Wilks' $\Lambda = .97$, $F(2, 202) = 2.74$, $p = .067$. The MANCOVA did not yield significant main effects for the gender of the therapist, Wilks' $\Lambda = .99$, $F(2, 202) = 0.79$, $p = .454$, or the gender of the client described in the vignette, Wilks' $\Lambda = .99$, $F(2, 202) = 0.62$, $p = .541$. Additionally, the interaction between the gender of the therapist and the gender of the client was not found to be significant, Wilks' $\Lambda = .99$, $F(2, 202) = 1.22$, $p = .299$.

The second MANCOVA conducted used SADRS Distraction and Egocentric as dependent variables (see Table 4). Results from the Box's M test indicated a lack of homogeneity of the covariance matrices, Box's M = 39.25, $F(9, 130092) = 4.28$, $p < .001$. Therefore, the significance of group differences on the dependent variables was determined using Pillai's Trace, which is more robust than Wilks' Lambda to the lack of homogeneity of the covariance matrices. Neither of the covariates were found to be significant in the analysis (BARS Negative Evaluation Factor, Pillai's Trace = .00, $F(2, 221) = 0.18$, $p = .837$; BARS Assertiveness, Pillai's Trace = .02, $F(2, 221) = 1.75$, $p = .177$). Similar to the results from the first MANCOVA, results from the second analysis failed to yield significant main effects for the gender of the therapist, Pillai's Trace = .00, $F(2, 221) = 0.10$, $p = .906$, the gender of the client, Pillai's Trace = .01, $F(2, 221) = 0.60$, $p = .552$, or the interaction between the gender of the therapist and the gender of the client, Pillai's Trace = .01, $F(2, 221) = 0.79$, $p = .456$. In sum, responses to disclosures of CSA were not found to be statistically significantly different from one another on the basis of the therapist's or client's gender.

Exploratory Sample Comparison Analyses

Post-hoc analyses were conducted on the study sample to explore any differences between the two participant pools: university counseling center psychologists and private practice psychologists. However, given the low sample size of university counseling center psychologists (n = 73), these analyses should be considered as strictly exploratory in nature, and any results should be interpreted with caution.

Similar to previous analyses, possible differences between the study samples were analyzed using two MANCOVA tests, with the first MANCOVA including SADRS Emotional Support/Belief and Tangible Aid/Information Support as dependent variables, and the second MANCOVA including SADRS Distraction and Egocentric as dependent variables. In both analyses, the type of psychologist (i.e., university counseling center or private practice psychologist) was entered as the independent variable, and BARS subscale scores were entered as covariates. Subsequent univariate analyses were conducted on all significant sources of variance in the MANCOVA models. Analyses indicated that private practice psychologists endorsed significantly more items on SADRS Emotional Support/Belief than university counseling center psychologists (see Tables 5, 6, and 7). Using Cohen's (1992) classification of effect sizes, this represented a "small" difference between private practice and university counseling center psychologists (d = 0.28).

Post-hoc Quantitative Analyses

As data was available from a similar unpublished thesis study by Karwan (2009) on college student responses to disclosures of childhood sexual abuse, and as this thesis study found significant differences between male and female respondents, whereas the present study did not, a question of interest became whether college students and therapists responded differently to

disclosures of childhood sexual abuse. The thesis study by Karwan consisted of $N = 173$ college student participants with an average age of $M = 19.3$ years. The respondents consisted of 71 males (41.0%) and 102 females (59.0%). Methodologically similar to the present study, the thesis study utilized a version of the SADRS designed for use with college students and asked participants to respond to the scale on the basis of a hypothetical disclosure of CSA from a close friend. The thesis study also utilized the same version of the BARS that was used in the present study.

Prior to statistically comparing the results of the SADRS from therapists and college students, average SADRS subscale scores were calculated for each subject to standardize the subscale scores. To test the comparison between therapists and college students, two MANCOVA tests were conducted. BARS subscale scores were entered as covariates in these analyses. In both analyses, the participant's group membership (i.e., therapist or college student) and the gender of the participant were entered as independent variables. Homogeneity of the covariance matrices was tested using the Box's M test.

In the first MANCOVA, which included SADRS Emotional Support/Belief and Tangible Aid/Information Support as dependent variables (see Table 8), the Box's M test indicated the presence of homogeneity of the covariance matrices, Box's M = 11.21, $F(9, 421318) = 1.23$, $p = .271$. Wilks' Lambda coefficients were used to determine the significance of group differences on the dependent variables. A significant main effect was found between therapists and college students, Wilks' $\Lambda = .67$, $F(2, 333) = 83.56$, $p < .001$. The main effect for participant gender was not found to be significant, Wilks' $\Lambda = .99$, $F(2, 333) = 2.01$, $p = .136$. The interaction effect between therapist/college student participant group and participant gender was also not found to be significant, Wilks' $\Lambda = 1.00$, $F(2, 333) = 0.50$, $p = .605$. The BARS Negative Evaluation

Factor was found to be a significant covariate in the model, Wilks' $\Lambda = .88$, $F(2, 333) = 23.33$, $p < .001$, whereas BARS Assertiveness was not, Wilks' $\Lambda = 1.00$, $F(2, 333) = 0.82$, $p = .440$.

Subsequent univariate analyses indicated a significant main effect between therapist and college student participants on SADRS Emotional Support/Belief, $F(1, 334) = 114.52$, $p < .001$, whereas the main effect for SADRS Tangible Aid/Information Support between therapists and college students was not found to be statistically significant, $F(1, 334) = 2.40$, $p = .123$. Group means indicated that college students scored significantly higher than therapists on SADRS Emotional Support/Belief (see Table 9). The effect size of this main effect was calculated using Cohen's *d*. According to Cohen's (1992) classification of effect sizes, there was a "large" difference between therapists and college students on SADRS Emotional Support/ Belief ($d = 1.47$).

SADRS Distraction and Egocentric were entered as dependent variables in the second MANCOVA (see Table 10). Results from the Box's M test indicated a lack of homogeneity of the covariance matrices, Box's M = 184.04, $F(9, 401817) = 20.20$, $p < .001$, indicating the use of Pillai's Trace to determine the significance of group differences on the dependent variables. The MANCOVA yielded significant main effects for the differences between therapists and college students, Pillai's Trace = .49, $F(2, 350) = 168.51$, $p < .001$, and male and female participants, Pillai's Trace = .03, $F(2, 350) = 4.85$, $p = .008$. The interaction effect between therapist/student participant group and participant gender was also found to be significant in this analysis, Pillai's Trace = .04, $F(2, 350) = 6.28$, $p = .002$. Similar to the first MANCOVA, the BARS Negative Evaluation Factor was found to be a significant covariate, Pillai's Trace = .02, $F(2, 350) = 3.51$, $p = .031$, whereas BARS Assertiveness was not, Pillai's Trace = .01, $F(2, 350) = 1.20$, $p = .302$.

Subsequent univariate analyses indicated significant main effects between therapist and college student participants on SADRS Distraction, $F(1, 351) = 281.22$, $p < .001$, and Egocentric subscales, $F(1, 351) = 168.58$, $p < .001$. Group means indicated that college students scored significantly higher than therapists on SADRS Distraction and Egocentric subscales (see Table 9). Using Cohen's (1992) classification of effect sizes, these main effects represented a "large" difference between therapists and college students on SADRS Distraction ($d = 1.87$) and Egocentric subscales ($d = 1.51$). Univariate analyses also yielded significant main effects for participant gender on SADRS Distraction, $F(1, 351) = 6.11$, $p = .014$, and Egocentric subscales, $F(1, 351) = 7.04$, $p = .008$. The interaction effects between therapist/college student participant group and participant gender were also found to be statistically significant on SADRS Distraction, $F(1, 351) = 8.47$, $p = .004$, and Egocentric subscales, $F(1, 351) = 8.59$, $p = .004$. Analysis of group means indicated that male college students scored significantly higher than female college students as well as male and female therapists on SADRS Distraction and Egocentric subscales (see Table 9).

Univariate analyses were also conducted to determine group differences on the BARS subscale scores. These analyses revealed significant main effects on the BARS Negative Evaluation Factor for therapist/college student participant group, $F(1, 372) = 38.86$, $p < .001$, and participant gender, $F(1, 372) = 4.44$, $p = .036$. The interaction between therapist/college student participant group and participant gender was not found to be significant for this BARS subscale, $F(1, 372) = 0.01$, $p = .934$. Group means indicated that therapists scored significantly higher on the BARS Negative Evaluation Factor than college students, and that males from both participant groups scored higher on the subscale than females (see Table 9). Of relevance to the present study, Cohen's *d* was calculated to estimate the effect size of the significant difference

between therapists and college students on BARS Negative Evaluation. Using Cohen's (1992) classification of effect sizes, this difference was found to be of "medium" size (d = 0.68). Univariate analysis on the BARS Assertiveness subscale revealed a significant main effect for participant gender, $F(1, 376) = 4.34$, $p = .038$, but failed to produce a significant main effect for therapist/college student participant group, $F(1, 376) = 1.50$, $p = .222$, or the interaction between participant group and participant gender, $F(1, 376) = 0.24$, $p = .622$.

Qualitative Analyses

Open and categorical coding techniques were used to analyze the qualitative data within responses to the Open-ended Disclosure Response Item. Undergraduate research assistants were trained by the author in qualitative data coding procedures. Research assistants were not made aware of the research questions or hypotheses.

In the first phase of coding, responses were coded independently by the research assistants using an open coding technique whereby responses were assigned conceptually descriptive first-order codes. For example, responses such as, "It must have taken a lot for you to feel able to share that with me," were given a first-order code of "Acknowledgment of Courage." The same set of responses was independently coded by multiple research assistants to ensure a high level of data saturation.

In the second phase of data analysis, research assistants were trained in identifying seven categories of disclosure responses, as proposed by Ullman (2000): Emotional Support/Belief, Treat Differently, Distraction, Take Control, Tangible Aid/Information Support, Victim Blame, and Egocentric. Research assistants worked independently in categorizing first-order codes into these broader, more abstract conceptual categories. The research assistants then compared these

second-order codes to ensure high reliability. Any discrepancies were discussed until an agreed-upon second-order code could be reached.

The data revealed that the vast majority of responses could be categorized into either the Emotional Support/Belief category or the Tangible Aid/Information Support category. Although not entirely absent in the dataset, very few responses were judged to be related to the Treat Differently, Distraction, or Egocentric categories. None of the responses were judged to be representative of the Take Control or Victim Blame categories. In fact, quite a few responses represented elements that could be seen as conceptually opposed to the negative social reaction categories. For instance, many responses made mention of giving the client complete control in the disclosure and therapy process. In sum, most participants provided responses that were judged to be emotionally supportive and/or providing some type of tangible support.

Many different types of responses were revealed within those judged to be representative of the Emotional Support/Belief category. Many respondents began by acknowledging the difficulty of disclosing such information, and the courage to be able to do so (e.g., "It must have taken a lot of courage for you to bring yourself to talk to me about this."). Related to this, many responses showed gratitude for the client being able to trust in the therapeutic relationship enough to make a disclosure of abuse (e.g., "I want to first thank you for your willingness to trust me with this - it must have been difficult for you to carry that with you all this time, but maybe even harder to tell me about it."). Another common theme among the responses was the attention paid to the immediate reactions and feelings of the client after disclosure (e.g., "I'd like to know what you are feeling now, after you've spoken about something that you have kept inside for so long."). Of note, while comments regarding the client's feelings about disclosing the abuse were quite common among the responses, comments inquiring about the client's

feelings related to the actual abuse were found to occur relatively infrequently. Less common, but still present within the dataset, were those responses that related to validating and normalizing the client's experience, with some responses specifically relating to normalizing any possible sexual arousal during the abuse (e.g., "I would normalize any patient feelings of anger, guilt, or physical satisfaction that she encountered in these events.").

Most responses judged to be representative of the Tangible Aid/Information Support category were related to mandated reporting laws (e.g., "I would set aside some time at the end to discuss whether there is a safety concern for other children and a need or a desire to report the sexual abuse."). Of note, the entirety of some of the participants' responses consisted of reporting obligations. Although mandated reporting of child abuse is specific to the ethical and legal obligations of disclosing CSA within a therapist-client relationship, Ullman (2000) found that survivors of sexual assault rated offers to help in reporting the assault to authorities as being a helpful form of tangible aid. Responses related to mandated reporting were thus judged to be conceptually similar enough to be categorized as Tangible Aid/Information Support. Another common theme within responses judged to be representative of the Tangible Aid/Information Support category was related to determining a future plan for therapy (e.g., "We would work on treatment planning together."). Some participants offered specific options for the future course of treatment, including anxiety management skills training and Eye Movement Desensitization and Reprocessing. Related to the previously mentioned validation and normalization of client responses, some responses included psychoeducation about some of the common effects of CSA and reactions following a disclosure of CSA (e.g., "I would likely provide some psychoeducation about psychological/emotional impact of disclosing one's trauma history and work with the client

to identify some safe coping skills to cope with any strong emotional reactions they might have afterwards.").

In analyzing the data, a number of common response themes emerged that did not seem to clearly fit into any one of Ullman's (2000) seven proposed categories of disclosure responses. These themes seemed primarily related to the specific context described in the Childhood Sexual Abuse Disclosure Vignette; that is, a disclosure of CSA occurring within the context of psychotherapy. One such theme was responses in which the participant made mention of their experience in working with survivors of CSA, presumably to increase the client's trust in the therapist (e.g., "I would let her know that I have experience in working with childhood sexual abuse and would be glad to help her."). Another context-specific theme which emerged was the assessment of symptoms (e.g., "I would assess his abuse history and ask about any PTSD symptoms that might be present."). Lastly, the therapist-client relationship, specifically related to transference reactions, was highlighted in some responses (e.g., "I would want to help him understand… the way in which he had been relating to me in treatment.").

In analyzing trends within the dataset, it should also be noted which types of responses occurred relatively infrequently. As previously mentioned, relatively few respondents inquired about the client's thoughts or feelings related to the abuse or the perpetrator. Additionally, only one participant made any mention of multicultural issues, stating that they would consider "any multicultural factors that may come into play."

As noted previously, the vast majority of responses within the dataset were judged to be representative of positive social reactions (i.e., Emotional Support/Belief and Tangible Aid/Information Support categories). However, some responses were judged to fall within the realm of negative social reactions. In what was identified as being representative of the Treat

Differently category, one respondent inquired of the client, “Have those behaviors caused you emotional pain and doubts about your sexuality?” This participant went on to question the veracity of the client’s account of abuse, asking, “Are you sure that is what happened?” The entirety of one participant’s response, which was judged to fall within the Distraction category, was as follows: “Tell me more about your uncle. Is he alive? Dead? Where does he live?” As an example of an Egocentric response, one participant stated, “There is nothing that burns me up more than adults hurting children.” In a rather atypical response, which was also judged to fall within the Egocentric category, another participant stated, “It's not fair and it's not right. It makes me angry too. If it was up to me, we would totally castrate your uncle for what he did to you.” In sum, although small in number, these negative responses were still found to be present in a dataset of largely positive responses.

CHAPTER 5: DISCUSSION

As preliminary analyses of the measures used in the present study led to some unexpected findings, these findings will be explicated prior to discussing study hypotheses. The SADRS subscales were found to be related to one another as expected, whereby those who scored highly on one positive social reaction subscale were likely to score highly on the other, a relationship which held true for the negative social reaction subscales as well. However, unexpectedly, SADRS Emotional Support/Belief was found to be positively related to both negative social reaction subscales. That is, endorsing emotionally supportive responses was predictive of also endorsing distracting and egocentric responses. Although conceptually dissimilar, one possible explanation for this finding is that giving more positive responses to a disclosure of CSA does not necessarily negate the possibility of also giving negative responses, and vice versa. That is, therapists may respond in helpful as well as hurtful ways to a disclosure.

The unexpected positive relationship between emotionally supportive responses and negative reactions may also suggest that disclosure responses are conceptually distinct from attitudes about CSA, which may be seen as more consistent (Rodriguez-Srednicki & Twaite, 1999). Findings from the present study may partially support this notion. As was expected, the positive social reaction subscales (i.e., SADRS Emotional Support/Belief and Tangible Aid/Information Support) were found to be positively related to holding positive attitudes toward survivors of CSA, and negatively related to holding negative attitudes toward survivors. However, neither of the negative social reaction subscales were found to be related to holding positive or negative attitudes toward survivors of CSA. Thus, findings from the present study lend support to the idea that negative, but not positive, reactions to a disclosure of CSA may be conceptually distinct from attitudes about survivors of CSA. One implication of these findings is

that well-meaning practitioners may still be unintentionally hurtful in their responses to disclosures of CSA, regardless of their feelings and attitudes toward survivors of CSA.

Another unexpected finding arising from the preliminary analyses was the low estimated reliability of the SMS Other-Directedness factor, indicating that therapists in the present study did not respond to the scale in a manner consistent enough to justify including scores from this measure in subsequent analyses. Given that the scale has been found to have acceptable estimated reliability in previous studies (e.g., Briggs & Cheek, 1988; Briggs et al., 1980; Kelley, Gelso, Fuertes, Marmarosh, & Lanier, 2010), the reasons for the scale's low observed consistency in the present study remain uncertain. As there have not been any previously published applications of the scale with therapist samples, more research may be needed to determine the effectiveness of the Other Directedness scale in being able to discriminate socially desirable response patterns in therapist samples.

Preliminary analyses raised questions about the effectiveness of the M-C SDS in the present study as well. Although therapists in the present study responded in a more consistent manner to the M-C SDS than the SMS Other-Directedness factor, none of the SADRS scales or individual items were found to be largely and significantly related to the M-C SDS. Thus, the M-C SDS was not found to be able to effectively identify SADRS scales or items which may be more susceptible to a socially desirable response style. Future use of the SADRS may require the development of built-in validity scales that may more effectively account and adjust for socially desirable response patterns.

The study hypotheses regarding group differences between male and female therapists in their responses to the SADRS were not confirmed by the data. That is, after accounting for attitudes toward survivors of CSA, there were no observed differences between male and female

therapists in believing and supporting the client, providing tangible aid and information, focusing on the therapist's own needs, or attempting to distract the client. These findings were inconsistent with previous research demonstrating that females tended to provide more helpful and less hurtful responses to disclosures of CSA than males (e.g., Back & Lips, 1998; Bornstein et al., 2007; Bottoms & Goodman, 1994; Cromer & Freyd, 2007; Karwan, 2009; McCoy & Gray, 2007; Mitchell et al., 1999; Quas et al., 2002; Rogers & Davies, 2007; Smith et al., 1988). It should be noted, however, that these previously cited studies did not utilize therapist samples. Thus, the results of the present study may be representative of an actual lack of difference between male and female therapists with regard to responses to disclosures of CSA, regardless of whether or not a difference exists within the general population.

Another explanation of these findings may be that, although differences do exist between male and female therapists, the SADRS may not have been sensitive enough to effectively detect these differences. Analysis of the qualitative data may provide support for this notion. The vast majority of respondents provided a response that was judged to be representative of providing emotional support and belief or tangible aid and information. However, a wide variety of responses were judged to be within these two positive social reaction categories, including acknowledgment of the client's courage, gratitude for sharing, attention to the client's immediate feelings and reactions, normalization of the client's reactions, inquiries about feelings related to the CSA, assistance in reporting the CSA to authorities, determining future plans for therapy, and providing psychoeducation. It may be that, although male and female therapists provide equivalent overall levels of positive reactions to disclosures of CSA, they may differ on the specific types of positive reactions they tend to provide. However, in its current state of development, the SADRS groups all of these positive reactions into two broad categories. Future

development of the SADRS may consider splitting these categories into subcategories based on the qualitative findings of the present study.

Qualitative data from the present study provided further indications of future directions in developing the SADRS to be more appropriate for use with therapists. Specifically, qualitative analyses yielded some responses specific to the context of therapy that were not clearly representative of any of the SADRS subscales. These included mention of the therapist's experience in working with survivors of CSA, presumably to increase perceptions of the therapist's credibility and the client's trust in the therapeutic process, assessment of trauma-related symptoms, and attention to possible transference reactions. Future development of the SADRS may also consider including these categories of responses if the scale is to be used with therapist populations.

As previous literature has been mixed regarding whether or not male and female survivors elicit different reactions when disclosing CSA, no specific hypotheses were made in the present study regarding such group differences. However, this question of group differences on disclosure reactions offered to male and female clients was examined in an exploratory fashion. It was found that male and female clients did not differ in the responses they elicited from participants in the present study in the four social reaction categories analyzed (i.e., believing and supporting the client, providing tangible aid and information, focusing on the therapist's own needs, and attempting to distract the client). It should be noted, however, that the present study assumed that therapists responding to the Childhood Sexual Abuse Disclosure Vignette were fully aware of the gender of the client described in the vignette. Future research could address this issue by including an independent manipulation check to determine the extent

to which participants are aware of key features of the CSA disclosure to which they are responding.

The lack of significant group differences in the present study prompted post-hoc questions regarding comparisons of the present study sample to that of previous research in which significant group differences were found. A comparison group was available in the form of data from an unpublished thesis study by Karwan (2009), in which differences were found between male and female college students in the tendency to give more or less hurtful responses to a disclosure of CSA from a friend. The thesis study utilized a similar methodology and many of the same measures used in the present study, allowing for direct comparisons across the two datasets.

The comparison of data from the present study to that of Karwan (2009) provided some unexpected findings, most notably that college students endorsed a significantly higher number of emotionally supportive responses than therapists. If reflective of an actual difference, this could indicate that therapists, whose training and job responsibilities include providing clients with emotional support, are less effective than a client's same-aged peers in offering this type of comfort and support. Specifically related to the context of disclosing one's history of CSA, these findings seem to indicate that clients may find it more helpful to disclose the abuse to their friends than to their therapist.

One possible explanation for why therapists would offer less emotional support than non-helping professionals to a survivor of CSA may be related to the high amount of exposure therapists presumably have to disclosures of abuse within their routine work duties. That is, therapists may be desensitized to the thoughts and feelings elicited from hearing a disclosure of CSA, an experience which non-helping professionals would presumably have less exposure to.

This may lead therapists to be less responsive to the emotional needs of a client disclosing CSA (Knight, 1997; Pistorius, Feinauer, Harper, Stahmann, & Miller, 2008). Another possible explanation for this finding is that therapists, presumably having more exposure to research on recovered and false memories, may approach disclosure situations with more skepticism than non-helping professionals, priming them to be less believing and, in turn, less emotionally supportive to clients disclosing CSA. Nachson et al. (2007) found some evidence for this idea that groups with more exposure to the debate on recovered memories would be less believing of a victim's statements. However, these explanations are predicated on the possibility that there is an actual difference between therapists and college students in the amount of emotional support provided after a disclosure of CSA. Other explanations should also be considered in understanding this unexpected finding.

One such explanation for the observed differences between therapists and college students on emotionally supportive responses may lie in the added responsibilities of handling a disclosure of CSA within the context of therapy versus a friend relationship. Specifically, therapists may focus more on the ethical and legal issues of reporting the abuse to authorities, obligations which are not necessarily present in friend relationships. Indeed, in examining the qualitative data from the present study, many respondents made mention of reporting obligations, with some responses consisting entirely of addressing mandated reporting issues. However, this idea that therapists may focus less on providing emotional support because they are more focused on providing tangible aid was not supported in the data, as there were no quantifiable differences between therapists and college students on providing tangible aid and information.

Another explanation for the observed differences between therapists and college students may be that therapists show emotional support in different ways than what was measured by the

SADRS. For example, the SADRS Emotional Support/Belief item, "Comfort them by telling them it will be alright or by holding them," although appropriate in a friend relationship, might raise boundary concerns within a therapist-client relationship. Furthermore, as previously mentioned, qualitative data from the present study seemed to indicate the presence of response patterns specific to the context of therapy that were not captured by the subscales of the present version of the SADRS. Future research should consider these therapy-specific response themes in further delineating how therapists may provide a different type of emotional support than that found in friend relationships. With regard to practice, findings from the present study may underscore the importance of building a client's social support network so that they may receive emotionally supportive responses that may not necessarily be provided, or even appropriate, in a therapeutic relationship.

Beyond these explanations, other unexpected findings from the post-hoc analyses offered further support for the presence of an actual difference between therapists and college students in providing emotionally supportive responses. Namely, it was found that therapists in the present study endorsed significantly more negative attitudes toward survivors of CSA than college students. This finding is more worrisome given that the present study found that having more negative attitudes toward survivors of CSA was related to showing less emotional support and tangible aid following a disclosure of CSA, a trend which has been confirmed elsewhere (Knight, 1997). Thus, if future research confirms that therapists do in fact harbor more negative attitudes toward survivors of CSA than the general public, it may be considered a significant issue in training and supervision. Specifically, therapists should be mindful of any negative attitudes and feelings they may have about survivors of CSA, and should use supervision and consultation in

appropriately addressing these issues so that they do not translate into less helpful services for survivors of maltreatment.

In considering the implications of the findings from the present study, important limitations in the study design should be considered. One area for such consideration is concerning the low response rates achieved from the online survey invitations. Although an acceptable total number of responses was achieved across participant pools, it is important to note that a response rate of only 6.9% was found in the initial participant pool of university counseling center psychologists, thus necessitating the broadening of the participant pool to include private practice psychologists. Sampling of this second participant pool yielded an increased, but still low, 17.8% response rate.

One reason for the low observed response rates in the present study may be related to the utilization of an online survey. In a meta-analysis of studies utilizing online surveys as well as other methods of delivering surveys, Manfreda, Bosnjak, Berzelak, Haas, and Vehovar (2008) found that online surveys yielded an 11% lower average response rate than other survey methods, including mail, telephone, and fax. However, although this may have partially accounted for the low response rates found in the present study, it is important to note that Manfreda et al. also found that online surveys yielded an average response rate of approximately 33%, a rate much higher than what was found in either participant pool of the present study. Another possible factor involved in the low response rates of the present study may be related to the population studied. Given the amount of research on therapist attitudes, beliefs, and practices, as well as the availability of therapist participant pools through online directories and e-mail listservs, it is likely that therapists receive a large number of invitations to participate in research. Thus, their response rates may be lower than that of the general population for the

simple reason that they likely receive a high volume of study requests and may not be able to respond to all of them. In support of this notion, other studies utilizing online survey methodology with therapist populations have yielded similarly low response rates (e.g., Gardner, 2008; Tunick, Mednick, & Conroy, 2011).

Perhaps the most problematic possible explanation for the low observed response rate in the present study is that those who responded to the online survey may have been different on key study variables from those that did not respond. For instance, it could be hypothesized that the therapists who volunteered to participate in the present study may have held more positive attitudes toward survivors of CSA and may have responded to a CSA disclosure in a more positive manner. In describing the methodological limitations of online surveys, Bethlehem (2010) warned of this very issue of self-selection bias in possibly underestimating group differences. Future research could address this issue by employing agency-wide participation methods, such as administering research protocols during a clinical staff meeting, and then comparing these results to that of an online survey methodology.

In addition to sample size concerns, it should also be noted that the dynamics of the study sample introduced other questions of experimental validity. Namely, the broadening of the participant pool to include private practice psychologists due to the low response rate from university counseling center psychologists was predicated on the assumption that the two groups of psychologists would be similar on key study variables. However, exploratory post-hoc sample analyses suggested that this may not have been the case for how much emotional support each group offered clients following a CSA disclosure. Although the difference was small in magnitude, it was found that private practice psychologists endorsed more emotionally supportive responses than university counseling center psychologists in the present study. It

should be noted, however, that given the small sample sizes of these participant pools in the present study, no definitive statements may be made regarding the likelihood that actual differences do exist between the two groups. Although there have been no studies to date that have directly assessed how psychologist work environments may affect responses to CSA disclosures, literature on how collegial support has been found to be positively related to therapist competence in working with survivors of abuse suggests that differences could occur in disclosure responses across work environments (Day, Thurlow, & Wolliscroft, 2003; Pistorius et al., 2008). Future research should address this question of how psychologist work environments may predict differences in responses to CSA disclosures.

Another limitation in the present study was concerning the use of vignettes to simulate a disclosure of CSA. Although the use of vignettes was chosen in an effort to standardize the disclosures, this did introduce questions about the study's generalizability to actual disclosures in therapy. Disclosures of CSA in therapy might be expected to elicit strong thoughts, feelings, and behaviors in the therapist receiving the disclosure. Reading a vignette of a hypothetical disclosure is unlikely to produce the same depth and breadth of these reactions. Indeed, in analyzing the qualitative responses, some participants noted the difficulty of providing a response to a disclosure of CSA when they were unable to be in the room with the client and accurately gauge how the client was feeling. One possible method of addressing this issue may be to transcribe actual therapy sessions in which disclosures of CSA occurred. However, aside from the pragmatic difficulties and ethical concerns of asking clients to submit very personal disclosures to research, such a method would seem highly unstandardized, introducing many confounding client variables into the study design. Another possible method to more realistically simulate the thoughts and feelings aroused from an actual disclosure of CSA may be through the

use of showing therapists videotapes of client actors reading a scripted disclosure of CSA in a therapy interaction. However, in utilizing such a method, it may prove difficult to manipulate only the actor's gender while holding constant any other potential mediating variables, such as attractiveness, emotional expressiveness, body/facial expressions, and so on. In weighing the costs and benefits of these individual study designs, it may be advisable for future research in the area to use a multi-method approach in attempting to capture the actual reactions of therapists to disclosures of CSA.

Findings from the present study may have implications on the therapeutic services offered to survivors of CSA. For one, as it has been found that survivors of CSA generally prefer to be assigned to a female therapist (Fowler & Wagner, 1993; Moon, Wagner, & Fowler, 1993; Yanico & Hardin, 1985), the lack of observed differences between male and female therapists in the present study points to the possibility that survivors of CSA will receive no better or worse treatment from a male therapist than from a female therapist. While this may be comforting to potential clients, other findings from the present study may offer new areas for concern. Specifically, the finding that therapists not only offered less emotionally supportive responses than college students, but also held more negative attitudes toward survivors of CSA, may further confirm clients' reported fears and experiences of receiving negative reactions from helping professionals (Draucker & Petrovic, 1997; Frenken & Van Stolk, 1990; Knight, 1997). These findings certainly warrant further investigation and possible modification of current clinical training and supervision practices.

Table 1

Intercorrelations Between SADRS Subscales

Subscale	1	2	3
1. Emotional Support/Belief			
2. Tangible Aid/Information Support	0.51*		
3. Distraction	0.29*	0.11	
4. Egocentric	0.26*	0.14	0.42*

Note. *$p < .008$ was the cutoff for statistical significance using a Bonferroni correction.

Table 2

Correlations Between SADRS Subscales and BARS Scales

SADRS Subscale	BARS Negative Evaluation Factor	BARS Assertiveness
Emotional Support/Belief	-0.41*	0.29*
Tangible Aid/Information Support	-0.25*	0.32*
Distraction	0.07	-0.09
Egocentric	-0.04	0.09

Note. $*p < .013$ was the cutoff for statistical significance using a Bonferroni correction.

Table 3

MANCOVA Results for SADRS Positive Social Reaction Subscales

Source	Value	*F*	*df*	*p*	Partial η^2
BARS Negative Evaluation Factor	.92	9.05	2, 202	.000	.08
Emotional Support/Belief		17.83	1, 203	.000	.08
Tangible Aid/Information Support		2.05	1, 203	.154	.01
BARS Assertiveness	.97	2.74	2, 202	.067	.03
Participant Gender	.99	0.79	2, 202	.454	.01
Client Gender	.99	0.62	2, 202	.541	.01
Participant Gender x Client Gender	.99	1.22	2, 202	.299	.01

Note. Wilks' Lambda reported for value.

Note. Univariate results presented following each significant source of variance in MANCOVA.

Table 4

MANCOVA Results for SADRS Negative Social Reaction Subscales

Source	Value	*F*	*df*	*p*	Partial η^2
BARS Negative Evaluation Factor	.00	0.18	2, 221	.837	.00
BARS Assertiveness	.02	1.75	2, 221	.177	.02
Participant Gender	.00	0.10	2, 221	.906	.00
Client Gender	.01	0.60	2, 221	.552	.01
Participant Gender x Client Gender	.01	0.79	2, 221	.456	.01

Note. Pillai's Trace reported for value.

Table 5

Sample Comparison MANCOVA Results for SADRS Positive Social Reaction Subscales

Source	Value	*F*	*df*	*p*	Partial η^2
BARS Negative Evaluation Factor	.90	11.70	2, 208	.000	.10
Emotional Support/Belief		22.34	1, 209	.000	.10
Tangible Aid/Information Support		1.73	1, 209	.189	.01
BARS Assertiveness	.97	3.08	2, 208	.048	.03
Emotional Support/Belief		0.43	1, 209	.515	.00
Tangible Aid/Information Support		5.85	1, 209	.016	.03
Psychologist Type (UCC or Private Practice)	.94	6.28	2, 208	.002	.06
Emotional Support/Belief		8.37	1, 209	.004	.04
Tangible Aid/Information Support		0.18	1, 209	.674	.00

Note. Wilks' Lambda reported as value.

Note. Univariate results presented following each significant source of variance in MANCOVA.

Table 6

Sample Comparison MANCOVA Results for SADRS Positive Negative Social Reaction Subscales

Source	Value	*F*	*df*	*p*	Partial η^2
BARS Negative Evaluation Factor	.00	0.06	2, 228	.945	.00
BARS Assertiveness	.01	1.25	2, 228	.228	.01
Psychologist Type (UCC or Private Practice)	.02	2.77	2, 228	.065	.02

Note. Pillai's Trace reported for value.

Table 7

University Counseling Center (UCC) and Private Practice Psychologist Participant Means and Standard Deviations on SADRS and BARS Subscales

	UCC Psychologist		Private Practice Psychologist	
Subscale	*M*	(*SD*)	*M*	(*SD*)
SADRS Emotional Support/Belief	92.93	(14.88)	97.18	(15.78)
SADRS Tangible Aid/Information Support	32.99	(5.35)	31.98	(6.23)
SADRS Distraction	13.09	(1.80)	14.32	(3.75)
SADRS Egocentric	10.11	(2.57)	10.23	(3.32)
BARS Negative Evaluation Factor	14.13	(6.46)	15.53	(5.86)
BARS Assertiveness	21.96	(3.43)	20.90	(3.81)

Table 8

Post-hoc MANCOVA Results for SADRS Positive Social Reaction Subscales

Source	Value	*F*	*df*	*p*	Partial η^2
BARS Negative Evaluation Factor	.88	23.33	2, 333	.000	.12
Emotional Support/Belief		42.38	1, 334	.000	.11
Tangible Aid/Information Support		23.63	1, 334	.000	.07
BARS Assertiveness	1.00	0.82	2, 333	.440	.01
Therapist/College Student Participant Group	.67	83.56	2, 333	.000	.33
Emotional Support/Belief		114.52	1, 334	.000	.26
Tangible Aid/Information Support		2.40	1, 334	.123	.01
Participant Gender	.99	2.01	2, 333	.136	.01
Participant Group x Participant Gender	1.00	0.50	2, 333	.605	.00

Note. Wilks' Lambda reported as value.

Note. Univariate results presented following each significant source of variance in MANCOVA.

Table 9

Therapist and College Student Participant Means and Standard Deviations on SADRS and BARS Subscales

		Therapist		College Student	
Subscale		*M*	(*SD*)	*M*	(*SD*)
SADRS Emotional Support/Belief	Male	3.46	(.57)	4.23	(.52)
	Female	3.59	(.57)	4.43	(.44)
SADRS Tangible Aid/Information Support	Male	3.98	(.74)	3.95	(.73)
	Female	4.05	(.75)	4.20	(.71)
SADRS Distraction	Male	1.16	(.23)	2.12	(.70)
	Female	1.17	(.29)	1.83	(.46)
SADRS Egocentric	Male	1.26	(.40)	2.24	(.76)
	Female	1.29	(.38)	1.91	(.60)
BARS Negative Evaluation Factor	Male	15.97	(5.89)	12.10	(5.56)
	Female	14.70	(6.13)	10.73	(4.30)
BARS Assertiveness	Male	20.78	(3.63)	21.08	(4.23)
	Female	21.45	(3.71)	22.17	(3.88)

Table 10

Post-hoc MANCOVA Results for SADRS Negative Social Reaction Subscales

Source	Value	*F*	*df*	*p*	Partial η^2
BARS Negative Evaluation Factor	.02	3.51	2, 350	.031	.02
Distraction		5.82	1, 351	.016	.02
Egocentric		0.03	1, 351	.861	.00
BARS Assertiveness	.01	1.20	2, 350	.302	.01
Therapist/College Student Participant Group	.49	168.51	2, 350	.000	.49
Distraction		281.22	1, 351	.000	.45
Egocentric		168.58	1, 351	.000	.32
Participant Gender	.03	4.85	2, 350	.008	.03
Distraction		6.11	1, 351	.014	.02
Egocentric		7.04	1, 351	.008	.02
Participant Group x Participant Gender	.04	6.28	2, 350	.002	.04
Distraction		8.47	1, 351	.004	.02
Egocentric		8.59	1, 351	.004	.02

Note. Pillai's Trace reported for value.

Note. Univariate results presented following each significant source of variance in MANCOVA.

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Appendix A

Demographic Information Form

Age:

Gender:

- Male
- Female

Ethnicity: (mark all that apply)

- African American/Black
- Asian or Pacific Islander
- Hispanic/Latino
- Native American or Alaskan Native
- White non-Hispanic
- Other (please specify below):

Degree: (mark all that apply)

- Ph.D.
- Psy.D.
- Ed.D.
- M.D.
- Other (please specify below):

Years of Clinical Experience as a Psychologist: (please enter a number)

Appendix B

Disclosure Vignette

Your individual therapy client, [Karl/Karla], whom you have been seeing for quite some time, says during a session that [he/she] has something very important that [he/she] has wanted to share with you for a long time. [He/She] says that when [he/she] was 9 years old, [he/she] and [his/her] uncle engaged in sexual acts numerous times over a period of several months. [He/She] tells you that [he/she] has never told anyone this before. After telling you about what happened, [he/she] silently waits for your response.

In the text box below, please write your response to the client's disclosure of childhood sexual abuse:

Appendix C

SADRS

Part I:

Instructions: After hearing your client disclose childhood sexual abuse to you, please indicate how likely you are to **do** each of the following:

1 = Very Unlikely
2
3
4
5 = Very Likely

	1 - Very Unlikely	2	3	4	5 - Very Likely
Tell them it was not their fault	○	○	○	○	○
Want to seek revenge on the perpetrator	○	○	○	○	○
Distract them with other things	○	○	○	○	○
Comfort them by telling them it will be alright or by holding them	○	○	○	○	○
Tell them that they are not to blame	○	○	○	○	○
Tell them to go on with their life	○	○	○	○	○
Tell them that they are loved	○	○	○	○	○
Reassure them that they are a good person	○	○	○	○	○
Encourage them to continue therapy	○	○	○	○	○
Say you feel personally wronged by their experience	○	○	○	○	○
Tell them to stop thinking about it	○	○	○	○	○
Listen to their feelings	○	○	○	○	○
See their side of things and not make judgments	○	○	○	○	○
Help them get information of any kind about coping with the experience	○	○	○	○	○
Express so much anger at the perpetrator that someone will have to calm you down	○	○	○	○	○
Tell them to stop talking about it	○	○	○	○	○
Show understanding for their experience	○	○	○	○	○
Reframe the experience as a clear case of victimization	○	○	○	○	○
Give them the number to Child Protective Services if they want to report what happened	○	○	○	○	○
Get so upset that you will need reassurance from someone	○	○	○	○	○

Try to discourage them from talking about the experience	○	○	○	○	○
Be able to really accept their account of their experience	○	○	○	○	○
Go over the session hour if they need more time	○	○	○	○	○
Tell them that they did not do anything wrong	○	○	○	○	○
Encourage them to keep the experience a secret	○	○	○	○	○
Show that you understand how they are feeling	○	○	○	○	○
Believe their account of what happened	○	○	○	○	○
Provide information and discuss options	○	○	○	○	○

SADRS

Part II:

Instructions: After hearing your client disclose childhood sexual abuse to you, please indicate how likely you are to **say** each of the following:

1 = Very Unlikely
2
3
4
5 = Very Likely

	1 - Very Unlikely	2	3	4	5 - Very Likely
"It wasn't your fault."	○	○	○	○	○
"I wish I could make the person that did this to you pay for what they did."	○	○	○	○	○
"Let's go for a walk. It'll help you take your mind off it."	○	○	○	○	○
"It'll be alright."	○	○	○	○	○
"I'm sorry for what you had to go through."	○	○	○	○	○
"You are not to blame."	○	○	○	○	○
"You need to move on with your life."	○	○	○	○	○
"You are still loved by people in your life."	○	○	○	○	○
"You're still a good person."	○	○	○	○	○
"I think it might be helpful for you to continue therapy."	○	○	○	○	○
"I personally feel hurt by what happened to you."	○	○	○	○	○
"You need to stop thinking about it."	○	○	○	○	○
"I'm here to listen to your feelings."	○	○	○	○	○
"I can see what you're going through, and I'm not here to judge you."	○	○	○	○	○
"I'll help you get information on anything that will help you cope with this."	○	○	○	○	○
"It makes me so angry to hear what happened to you!!!"	○	○	○	○	○
"You need to stop talking about it."	○	○	○	○	○
"You were victimized by someone who took advantage of you."	○	○	○	○	○
"I can help you make a report to Child Protective Services if you want to report what happened."	○	○	○	○	○
"I'm so mad right now, I just need to know that everything's going to be alright."	○	○	○	○	○

“I think we should talk about something else.”	◯	◯	◯	◯	◯
“I believe you.”	◯	◯	◯	◯	◯
“We can go over our session time if you would like more time today."	◯	◯	◯	◯	◯
“You didn’t do anything wrong.”	◯	◯	◯	◯	◯
“You shouldn’t tell anyone else about this.”	◯	◯	◯	◯	◯
“I know you are telling me the truth.”	◯	◯	◯	◯	◯
“We can talk about the different options you have to help you cope with this.”	◯	◯	◯	◯	◯

Appendix D

BARS

Instructions: Please rate the person you read about in the vignette (i.e., the client who disclosed childhood sexual abuse to you) on each of the following adjective pairs. For each adjective pair, please indicate the extent to which one adjective in the pair describes the person you read about in the vignette better than the other adjective in the pair by choosing a point, with the point to the far left indicating that the adjective on the left completely describes the person in the vignette, the point to the far right indicating that the adjective on the right completely describes them, and the point in the middle indicating that they can be equally described by both adjectives in the pair.

good	○	○	○	○	○	○	○	bad
moral	○	○	○	○	○	○	○	immoral
dirty	○	○	○	○	○	○	○	clean
blameless	○	○	○	○	○	○	○	blameworthy
dishonest	○	○	○	○	○	○	○	honest
innocent	○	○	○	○	○	○	○	guilty
cowardly	○	○	○	○	○	○	○	brave
assertive	○	○	○	○	○	○	○	unassertive
strong	○	○	○	○	○	○	○	weak
healthy	○	○	○	○	○	○	○	unhealthy

Appendix E

SMS

Directions: The statements below concern your personal reactions to a number of different situations. No two statements are exactly alike, so consider each statement carefully before answering. If a statement is *TRUE* or *MOSTLY TRUE* as applied to you, choose answer choice *True*. If a statement is FALSE or *NOT USUALLY TRUE* as applied to you, choose answer choice *False*. It is important that you answer as frankly and as honestly as you can. Your answers will be kept in the strictest confidence.

	True	False
My behavior is usually an expression of my true inner feelings, attitudes, and beliefs.	○	○
At parties and social gatherings, I do not attempt to do or say things that others will like.	○	○
I guess I put on a show to impress or entertain people.	○	○
When I am uncertain how to act in social situations, I look to the behavior of others for cues.	○	○
In different situations and with different people, I often act like very different persons.	○	○
Even if I am not enjoying myself, I often pretend to be having a good time.	○	○
I'm not always the person I appear to be.	○	○
I would not change my opinions (or the way I do things) in order to please someone else or win their favor.	○	○
In order to get along and be liked, I tend to be what people expect me to be rather than anything else.	○	○
I feel a bit awkward in company and do not show up quite as well as I should.	○	○
I may deceive people by being friendly when I really dislike them.	○	○

Appendix F

M-C SDS
Personal Reaction Inventory

Instructions: Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is True or False as it pertains to you personally.

	True	False
Before voting I thoroughly investigate the qualifications of all the candidates.	○	○
I never hesitate to go out of my way to help someone in trouble.	○	○
It is sometimes hard for me to go on with my work if I am not encouraged.	○	○
I have never intensely disliked anyone.	○	○
On occasion I have had doubts about my ability to succeed in life.	○	○
I sometimes feel resentful when I don't get my way.	○	○
I am always careful about my manner of dress.	○	○
My table manners at home are as good as when I eat out in a restaurant.	○	○
If I could get into a movie without paying and be sure I was not seen I would probably do it.	○	○
On a few occasions, I have given up doing something because I thought too little of my ability.	○	○
I like to gossip at times.	○	○
There have been times when I felt like rebelling against people in authority even though I knew they were right.	○	○
No matter who I'm talking to, I'm always a good listener.	○	○
I can remember "playing sick" to get out of something.	○	○
There have been occasions when I took advantage of someone.	○	○
I'm always willing to admit when I make a mistake.	○	○
I always try to practice what I preach.	○	○
I don't find it particularly difficult to get along with loud mouthed, obnoxious people.	○	○
I sometimes try to get even rather than forgive and forget.	○	○
When I don't know something I don't at all mind admitting it.	○	○
I am always courteous, even to people who are disagreeable.	○	○
At times I have really insisted on having things my own way.	○	○
There have been occasions when I felt like smashing things.	○	○
I would never think of letting someone else be punished for my wrong-doings.	○	○
I never resent being asked to return a favor.	○	○
I have never been irked when people expressed ideas very different from my own.	○	○
I never make a long trip without checking the safety of my car.	○	○
There have been times when I was quite jealous of the good fortune of others.	○	○
I have almost never felt the urge to tell someone off.	○	○

I am sometimes irritated by people who ask favors of me.	◯	◯
I have never felt that I was punished without cause.	◯	◯
I sometimes think when people have a misfortune they only got what they deserved.	◯	◯
I have never deliberately said something that hurt someone's feelings.	◯	◯

Appendix G

Dear [UCC Training Director]:

My name is Arvind Karwan, and I am a student in the Counseling Psychology graduate program at Colorado State University. For my dissertation, I will be examining how psychologists respond to disclosures of childhood sexual abuse. My dissertation research has been approved by Colorado State University's Institutional Review Board (IRB ID# 10-1894H). Would you please forward this request to psychologists on staff at your university counseling center? The study should only take approximately 15-20 minutes to complete. The link to my survey can be found at:

http://colostatepsych.qualtrics.com/SE/?SID=SV_1TwOBTjO1Tm7Xus
title: Therapist Responses to Childhood Sexual Abuse Disclosures

Thank you so much for your help in my research project!! Please let me know if you have any questions or comments.

Thank you,
Arvind Karwan, M.S.
Counseling Psychology Program
Department of Psychology
Colorado State University
e-mail: akarwan@rams.colostate.edu
phone: (970) 690-0780

Appendix H

Dear [UCC Training Director]:

My name is Arvind Karwan, and I am a student in the Counseling Psychology graduate program at Colorado State University. As you may recall, I had recently sent a request for participation in an online survey regarding how psychologists respond to disclosures of childhood sexual abuse. Unfortunately, I have not received an adequate number of responses to complete my dissertation research, and would like to ask that you please forward this second request to psychologists on staff at your university counseling center. My dissertation research has been approved by Colorado State University's Institutional Review Board (IRB ID# 10-1894H). The study should only take approximately 15-20 minutes to complete. The link to my survey can be found at:

http://colostatepsych.qualtrics.com/SE/?SID=SV_1TwOBTjO1Tm7Xus
title: Therapist Responses to Childhood Sexual Abuse Disclosures

Thank you so much for your help in my research project!! Please let me know if you have any questions or comments.

Thank you,
Arvind Karwan, M.S.
Counseling Psychology Program
Department of Psychology
Colorado State University
e-mail: akarwan@rams.colostate.edu
phone: (970) 690-0780

Appendix I

Dear [UCC Training Director]:

My name is Arvind Karwan, and I am a student in the Counseling Psychology graduate program at Colorado State University. As you may recall, a few weeks ago I had sent a couple of requests for participation in an online survey regarding how psychologists respond to disclosures of childhood sexual abuse. Unfortunately, I have not received an adequate number of responses to complete my dissertation research, and would like to ask that you please forward this third and final request to psychologists on staff at your university counseling center. My dissertation research has been approved by Colorado State University's Institutional Review Board (IRB ID# 10-1894H), and is being supervised by Dr. Ernest Chavez. The study should only take approximately 15-20 minutes to complete. The link to my survey can be found at:

http://colostatepsych.qualtrics.com/SE/?SID=SV_1TwOBTjO1Tm7Xus
title: Therapist Responses to Childhood Sexual Abuse Disclosures

In an effort to improve the response rate and to thank those who take the study, for every completed study response, I will personally donate $1 to the Rape, Abuse & Incest National Network (RAINN; http://www.rainn.org), the largest national anti-sexual violence organization. The donation amount will also include the number of responses that I have previously received from my first two requests.

Thank you so much for your help in my research project!! Please let me know if you have any questions or comments.

Thank you,
Arvind Karwan, M.S.
Counseling Psychology Program
Department of Psychology
Colorado State University
e-mail: akarwan@rams.colostate.edu
phone: (970) 690-0780

Appendix J

Dear [Psychologist]:

My name is Arvind Karwan, and I am a student in the Counseling Psychology graduate program at Colorado State University. For my dissertation, I will be examining how psychologists respond to disclosures of childhood sexual abuse. My dissertation research has been approved by Colorado State University's Institutional Review Board (IRB ID# 10-1894H), and is being supervised by Dr. Ernest Chavez. It would be greatly appreciated if you could please take a moment to complete the study. The study should only take approximately 15-20 minutes to complete. The link to my survey can be found at:

http://colostatepsych.qualtrics.com/SE/?SID=SV_1TwOBTjO1Tm7Xus
title: Therapist Responses to Childhood Sexual Abuse Disclosures

In an effort to improve the response rate and to thank those who take the study, for every completed study response, I will personally donate $1 to the Rape, Abuse & Incest National Network (RAINN; http://www.rainn.org), the largest national anti-sexual violence organization.

Thank you so much for your help in my research project! I will be sending a reminder e-mail in two weeks just to ensure that those who wish to participate remember to do so. Please let me know if you have any questions or comments.

Thank you,
Arvind Karwan, M.S.
Counseling Psychology Program
Department of Psychology
Colorado State University
e-mail: akarwan@rams.colostate.edu
phone: (970) 690-0780

Appendix K

Dear [Psychologist]:

My name is Arvind Karwan, and I am a student in the Counseling Psychology graduate program at Colorado State University. As you may recall, I had recently sent a request for participation in an online survey regarding how psychologists respond to disclosures of childhood sexual abuse. Unfortunately, I have not received an adequate number of responses to complete my dissertation research, and would like to ask that you please take a moment to complete the study. My dissertation research has been approved by Colorado State University's Institutional Review Board (IRB ID# 10-1894H), and is being supervised by Dr. Ernest Chavez. The study should only take approximately 15-20 minutes to complete. The link to my survey can be found at:

http://colostatepsych.qualtrics.com/SE/?SID=SV_1TwOBTjO1Tm7Xus
title: Therapist Responses to Childhood Sexual Abuse Disclosures

In an effort to improve the response rate and to thank those who take the study, for every completed study response, I will personally donate $1 to the Rape, Abuse & Incest National Network (RAINN; http://www.rainn.org), the largest national anti-sexual violence organization.

Thank you so much for your help in my research project! Please let me know if you have any questions or comments.

Thank you,
Arvind Karwan, M.S.
Counseling Psychology Program
Department of Psychology
Colorado State University
e-mail: akarwan@rams.colostate.edu
phone: (970) 690-0780

Appendix L

Consent to Participate in a Research Study
Colorado State University

TITLE OF STUDY: Therapist Responses to Childhood Sexual Abuse Disclosures

PRINCIPAL INVESTIGATOR: Ernest L. Chavez, Ph.D.
ernest.chavez@colostate.edu
970-491-6364

CO-PRINCIPAL INVESTIGATOR: Arvind K. Karwan, M.S.
akarwan@rams.colostate.edu
970-690-0780

WHY AM I BEING INVITED TO TAKE PART IN THIS RESEARCH? This study is interested in psychologists' responses to client childhood sexual abuse disclosures. As a psychologist, we would like to better understand how you and other psychologists respond to such disclosures in a therapy setting.

WHO IS DOING THE STUDY? Dr. Ernest Chavez and Arvind Karwan, both affiliated with the Psychology Department at Colorado State University, will be conducting the study.

WHAT IS THE PURPOSE OF THIS STUDY? The purpose of this research project is to investigate the factors involved in how psychologists respond to disclosures of childhood sexual abuse.

WHAT WILL I BE ASKED TO DO? To help us understand how psychologists respond to disclosures of childhood sexual abuse, we will be asking you to read a vignette describing a client disclosure of childhood sexual abuse. You will then be asked to type out a response to the disclosure, and then fill out three (3) questionnaires regarding the vignette. Some of the questions ask about different verbal and behavioral responses to a disclosure of childhood sexual abuse. Other questions ask about your attitudes toward victims of childhood sexual abuse. In addition, we will be asking you to fill out a demographic information form which will ask you to report your age, gender, ethnicity, degree, and years of clinical experience as a psychologist.

ARE THERE REASONS WHY I SHOULD NOT TAKE PART IN THIS STUDY? If you have had a prior history of abuse, whether personal or family or friends, you may not want to participate in the study, as reading about a case of childhood sexual abuse and answering questions related to the case may cause psychological distress.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

- As a result of discussing a sensitive topic like child abuse, you may experience some psychological distress. This risk may be greater if you have had a prior history of abuse, whether personal or family or friends.
- Should you experience psychological distress as a result of participating in the present study, you may wish to call the National Sexual Assault Hotline at 1-800-656-HOPE, which provides free and confidential support and information.
- It is not possible to identify all potential risks in research procedures, but the researcher(s) have taken reasonable safeguards to minimize any known and potential, but unknown, risks.

ARE THERE ANY BENEFITS FROM TAKING PART IN THIS STUDY? At the completion of the study, participants will receive information on research about the types of responses victims of sexual abuse have rated as being more or less helpful. There are no direct benefits to the participant for participating in this study. However, at the conclusion of the study, participants will receive information on research about responses to disclosures of childhood sexual abuse, which may help increase competence in this area and may be used to inform treatment for adult victims of childhood sexual abuse. In addition, for each

completed study protocol, $1.00 will be donated upon completion of the study to the Rape, Abuse & Incest National Network (RAINN), the largest national anti-sexual violence organization. The organization provides many advocacy services for victims of sexual assault, including the aforementioned National Sexual Assault Hotline (1-800-656-HOPE). More information about RAINN may be found at http://www.rainn.org.

DO I HAVE TO TAKE PART IN THE STUDY? Your participation in this research is voluntary. If you decide to participate in the study, you may withdraw your consent and stop participating at any time without penalty or loss of benefits to which you are otherwise entitled.

WHAT WILL IT COST ME TO PARTICIPATE? There will be no cost to you for participating in this study.

WHO WILL SEE THE INFORMATION THAT I GIVE?
We will keep private all research records that identify you, to the extent allowed by law.

Your information will be combined with information from other people taking part in the study. When we write about the study to share it with other researchers, we will write about the combined information we have gathered. You will not be identified in these written materials. We may publish the results of this study; however, we will keep your name and other identifying information private.

This study is anonymous. That means that no one, not even members of the research team, will know that the information you give comes from you.

You will not be asked to provide any information that can identify you, like your name, on any of the questionnaires you fill out.

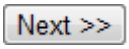
CAN MY TAKING PART IN THE STUDY END EARLY? You may choose to withdraw your consent and stop participating at any time during this session without penalty or loss of benefits to which you are otherwise entitled.

WILL I RECEIVE ANY COMPENSATION FOR TAKING PART IN THIS STUDY? No compensation will be offered to participants for taking part in this study.

WHAT HAPPENS IF I AM INJURED BECAUSE OF THE RESEARCH? The Colorado Governmental Immunity Act determines and may limit Colorado State University's legal responsibility if an injury happens because of this study. Claims against the University must be filed within 180 days of the injury.

WHAT IF I HAVE QUESTIONS? Before you decide whether to accept this invitation to take part in the study, please contact the principal investigator, Dr. Ernest Chavez, with any questions you may have. At any time after participating in the study, you are also welcome to contact the principal investigator if you have questions that come to mind about the study. If you have any questions about your rights as a volunteer in this research, contact Janell Barker, Human Research Administrator at 970-491-1655. You are encouraged to print a copy of this consent form for your records.

By proceeding (i.e., clicking the “Next” button), you acknowledge that you have received and read the consent information stated above and are willingly participating in the study.



Appendix M

DEBRIEFING FORM

PRINCIPAL INVESTIGATOR: Ernest L. Chavez, Ph.D.
ernest.chavez@colostate.edu
970-491-6364

CO-PRINCIPAL INVESTIGATOR: Arvind K. Karwan, M.S.
akarwan@rams.colostate.edu
970-690-0780

Thank you for your participation in this study! The purpose of this study is to find out how male and female therapists respond differently to disclosures of childhood sexual abuse from male and female survivors. Disclosing sexual abuse has been shown to be beneficial to survivors in some cases, and hurtful in others. The difference appears to be how others respond to the disclosure. In a study conducted by Ullman (2000), adult victims of sexual assault reported that the most helpful reactions to a disclosure were responses such as being believed and being offered tangible aid and support, while the least helpful responses were being blamed, treated differently, controlled, and encouraged to keep the abuse a secret. In an unpublished thesis study conducted by the investigators listed above (available upon request), it was found that male college students tended to give more hurtful responses and female college students tended to give more helpful responses to hypothetical disclosures of sexual abuse from a friend. The investigators of this study are seeking to investigate whether this pattern exists in male and female therapists, which has implications for training and the treatment of adult survivors of childhood sexual abuse.

Your participation in this study is greatly appreciated and will help us gain a better understanding of how we may help sexual abuse survivors. For your participation, $1.00 will be donated upon completion of the study by the research team to the Rape, Abuse & Incest National Network (RAINN) for your completed research protocol and every other completed research protocol we have received. RAINN is the largest national anti-sexual violence organization, and provides many advocacy services for victims of sexual assault. More information about RAINN may be found at http://www.rainn.org.

Because this is an on-going study, we ask that you please do not discuss the purpose of this study with anyone that may serve as a participant for the study. If you would like to discuss this research study in further detail, please contact one of the investigators listed above. Additionally, if you feel you have experienced any psychological distress as a result of participating in this study, or if you have had a prior history of abuse, whether personal or family or friends, you may wish to call the RAINN National Sexual Assault Hotline at 1-800-656-HOPE, which provides free and confidential support and information. See the informed consent form presented at the start of this study for more information on liability.

If you would like an electronic copy of the results of this study once they become available, please send an e-mail request to the Co-investigator, Arvind Karwan, at akarwan@rams.colostate.edu.

Citation:
Ullman, S. E. (2000). Psychometric characteristics of the Social Reactions Questionnaire: A measure of reactions to sexual assault victims. Psychology of Women Quarterly, 24, 257-271.