Walden University

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Walden University
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Abstract

Self-Disclosure and Gender of a Therapist: Its Effect on Adult Client Willingness to Self-Disclose

by

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MA, Walden University, 2019

MA, Montclair State University, 1983

MAE, Seton Hall University, 1981

BS, Montclair State College, 1976

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Clinical Psychology

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Abstract

There has been much controversy over the past several decades concerning therapist self-disclosure with clients. Although many psychologists believe that revealing anything about themselves would be inappropriate, some psychologists believe in using various forms of self-disclosure with their clients. Society and culture have changed drastically in recent decades concerning gender roles and expectations of therapeutic interventions. In light of these changes, there is a lack of information about whether a client's willingness to self-disclose is related to the type of therapist self-disclosure and to the gender of the therapist. Therefore, the purpose of this study was to explore whether there is a current relationship between a therapist's gender and the type of therapist self-disclosure (i.e., factual, empathetic, or no self-disclosure) and a client's willingness to self-disclose. To test these hypotheses, this quantitative study was designed to determine whether there are any main and interaction effects between a therapist's gender and type of therapist self-disclosure and a client's willingness to self-disclose. Using Bandura's social learning theory and Beck's modeling theory as the foundation for this study, adults were surveyed across the United States who had been in therapy. The data were collected using the Counselor Self-Disclosure Scale and the Emotional Self-Disclosure Scale via SurveyMonkey. A two-way ANOVA was used to analyze the data. A significant connection was found concerning the gender and type of therapist self-disclosure and a client's willingness to self-disclose. Consequently, psychologists can implement types of therapist self-disclosure in order to generate client willingness to talk, which may facilitate positive therapeutic outcomes for the patient.

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Dedication

Although my parents are no longer alive, I want to thank them for setting many examples over the years of how to work hard and persevere with your passion. They also taught me to be respectful of my educators and elders, take their advice and criticism humbly, and complete the project I set out to do. Last, I would like to thank my Evelyn, who stood by me over the many years while working on my doctorate and dissertation.

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Chapter 1: Introduction to the Study

Introduction

There has been much controversy concerning therapist self-disclosure with clients for the past several decades. Many psychologists believe in the Freudian tradition of revealing nothing about themselves. On the other hand, some psychologists believe in using various forms of self-disclosure with their clients. All therapists reveal intentionally and unintentionally something about themselves during a therapeutic session. Examples of therapist self-disclosure include clothing, jewelry, a wedding ring, gender, or a verbal statement related to the therapist's beliefs. There is increasing evidence of therapist self-disclosures having a positive effect on therapy (Lee, 2014; Levitt, 2015). Dazkir and Read (2012) have discovered that client self-disclosure facilitates positive therapeutic outcomes for the patient. Hill et al. (2018) have echoed the findings of Dazkir and Read (2012).

A current review of the literature shows a paucity of data concerning the type of self-disclosures presented by therapists. As noted by Lee (2014), there is a need for further study concerning what type of therapist self-disclosures engage rather than disengage the client to self-disclose. Currently, psychologists do not know what types of self-disclosures by therapists will elicit self-disclosures by clients.

Another area of needed study is whether the gender of the therapist and their self-disclosures will engender self-disclosures from clients. What is known is that women tend to disclose more than men for both causal and best friend relationships (Chinonso & Barnabas, 2017). What is not known is whether male or female therapists will engender

more self-disclosures from clients within today's culture. The gender of the therapist may be an essential variable because some clients may prefer one gender over the other. Consequently, clients may self-disclose more or less during therapy based on the therapist's gender.

Chapter 1 provides an overview of this research study. This section includes background information on therapist self-disclosure and its effect on a client's willingness to self-disclose, as well as the therapist's gender and its effect on a client's willingness to self-disclose. The problem statement and purpose of the study are included with several research questions related to the gap in the literature. A detailed description of Bandura's social learning theory and its relevance to the relationship between therapist self-disclosure and client willingness to self-disclose is included. Furthermore, the nature of this study, operational definitions, assumptions, scope, and limitations are explained. The significance of this study concerning the gap as to whether the type of therapist self-disclosure and the therapist's gender are related to the willingness of a client to self-disclose is discussed. Also, how the findings may contribute to the field of psychotherapy will be deliberated, and a discussion related to promoting positive social change will be promulgated. After all, the ultimate goal of therapy is to help clients improve their lives (American Psychological Association, 2010; National Council of Schools and Programs in Professional Psychology [NCSPP], 2007). Last, a summary is provided that highlights the main issues in Chapter 1.

Background

Therapist self-disclosure has been a longstanding controversial issue in both the counseling and psychotherapy fields (Danzer, 2019; LaPorte et al., 2010). Within the past decade, this topic has been researched and tested by many psychologists (Bitar et al., 2014). Psychologists have explored the meaning of therapist self-disclosure and what are appropriate and inappropriate therapist self-disclosures, as well as when to engage or not to engage in these disclosures (Bottrill et al., 2010). Also, the ethics of therapist self-disclosure must be taken into consideration because therapists must adhere to Principle A: Beneficence and Nonmaleficence (American Psychological Association, 2010) and avoid harm to their clients. According to LaPorte et al. (2010), the therapist must decide how much information to reveal because too much information may be perceived by the client as boundary-crossing and too little may be interpreted as aloofness. The reality is that most therapists reveal something about themselves to their clients (Danzer, 2019; Henretty & Levitt, 2010).

Although there has been much controversy concerning therapist self-disclosure to a client, there is empirical evidence of therapist self-disclosures that have had positive therapeutic outcomes for the client (Lee, 2014; Levitt et al., 2015). Hill et al. (2018) found that therapist self-disclosures were strongly related to a client's willingness to self-disclose and open up during therapy. On the other hand, there is not much research on the type of therapist self-disclosure that may or may not enhance a client's willingness to self-disclose; therefore, there is a gap in the literature that needs to be studied.

Lee (2014) emphasized a need to explore what types of therapist self-disclosures increase or decrease client self-disclosures. Pinto-Coelho et al. (2018) found many therapist self-disclosures that reduced the number of client self-disclosures. In this study, I examined two types of therapist self-disclosure (i.e., empathetic and factual). Empathetic disclosures demonstrate kindness, understanding, and respect toward the client's problems (Ivey et al., 2014; Rogers, 1961). Factual disclosures involve statements that are informational and related to a client's problems (Brew & Kottler, 2008). Both types of therapist self-disclosure are explained further in Chapter 2.

Another variable that was examined was the relationship between a therapist's gender and a client's willingness to self-disclose. According to Danzer (2019) and Staczan et al. (2017), the effects of a therapist's gender on a client's willingness to engage in self-disclosure have been studied for several decades. Many of these studies have found no evidence of therapist gender having any effect on a client's willingness to self-disclose (Henretty & Levitt, 2010); however, societal values and beliefs have changed over the last several decades (Fiske, 2014; Fiske et al., 2010). Therefore, it is not known what connection there is between a therapist's gender and a client's willingness to self-disclosure in today's society. Consequently, this gap in the research needs to be addressed.

This current study is needed because it addresses two gaps in the literature. I investigated a therapist's type of self-disclosure and sought to determine whether it is associated with a client's willingness to self-disclose. The other gap involves a therapist's gender and a client's willingness to self-disclose in today's society. Closing these gaps

may help therapists to decide when to engage self-disclosure and what type of self-disclosure to use, as well as indicate whether the gender of a therapist has any connection with a client's willingness to self-disclose in the current culture (Burkholder et al., 2016).

Problem Statement

There were two research problems in this study. One problem was the need to determine if a client's willingness to self-disclose is related to the type of therapist self-disclosure. Lee (2014) pointed out the need for further study in this area because his findings were inconclusive. Some therapist self-disclosures decreased the number of client self-disclosures, and other therapist self-disclosures were harmful. Those therapist self-disclosures did not facilitate positive therapeutic outcomes. Pinto-Coelho et al. (2018) also found that some types of therapist self-disclosures decreased the number of client self-disclosures. The other problem was a client's perception of a therapist's gender and its relevance to a client's willingness to self-disclose. Some clients may be uncomfortable before therapy begins with a particular gender because of past negative experiences with that gender. Past research has found no connection between a therapist's gender and a client's willingness to self-disclose (Danzer, 2019; Henretty & Levitt, 2010; Staczan et al., 2017); however, Liddon et al. (2018) found that some clients produced fewer self-disclosures because of the therapist's gender. American society has changed significantly concerning gender roles since this research was conducted decades ago (Fiske et al., 2010). Current research is lacking in this area, and I intended to determine if there is any connection between a therapist's gender and a client's willingness to self-

disclose within American current culture. If there is such a connection, then clients need to have a choice of what gender the therapist is before the start of therapy.

Therapist self-disclosure has been a hotly debated topic for decades (Danzer, 2019). Moreover, there is a need to explore the type of therapist self-disclosure and its connection to a client's self-disclosure. As noted by Lee (2014), there is a need for further study concerning what type of therapist self-disclosures engage rather than disengage the client to self-disclose. Pinto-Coelho et al. (2018) found several types of therapist self-disclosures that were unsuccessful and harmful. Pinto-Coelho et al. pointed out that "clients had negative reactions, such as anger, impatience, withdrawal, and feeling criticized or judged" (p. 445). "One client 'slipped into this shell of pleasantry' and stopped disclosing. Another client responded with anger and terminated therapy soon thereafter" (Pinto-Coelho et al., p. 445). Hill et al. (2018) echoed that there was a need for "empirical evidence about TSD [therapist self-disclosure]" (p. 445) and its efficacy in engaging a client to self-disclose.

The other relevant problem is whether the gender of the therapist and their self-disclosures will be related to self-disclosures from clients. What I do know is that women tend to disclose more than men for both causal and best-friend relationships (Chinonso & Barnabas, 2017; Sheldon, 2013). I also know that Jones and Zoppel (1982) found that clients during a post hoc study stated that they felt female therapists developed better therapeutic alliances than male therapists. Staczan et al. (2017) discovered that female therapists intervened more empathetically while male therapists were more confrontational with clients. Behn et al. (2018) found insignificant differences concerning

the gender of the therapist and the alliance relationship. They pointed out that there were too many intervening variables that limited the results of whether the gender of the therapist had any effect on a client's willingness to self-disclose (i.e., clients were not given a choice as to which gender they wanted for their therapist, the age of the therapist, and the income level of the therapist). In other words, this study had too many interaction effects and did not determine specifically whether there is any relationship between a therapist's gender and a client's willingness to self-disclose.

Knowing whether the gender of the therapist is related to client self-disclosures is also important. Bhati (2014) found mixed results in other similar studies mentioned above. In addition, Bhati raised the question of whether self-disclosures from the client will continue later during therapy. Last, Larson and Anderson (2019) discovered that male depression is unique, and when not provided a choice of the therapist's gender, men tend to avoid counseling. Current research is needed to determine whether the gender of the therapist is related to more self-disclosures or not from clients, since societal norms have changed drastically during the past 20 to 30 years (Fiske, 2014).

Consequently, I attempted to fill two gaps in this research. There is a current need to determine what types of therapist self-disclosures may engage a client to self-disclose. Also, I wanted to discover if the gender of the therapist is related to a client's willingness to self-disclose in today's society (Fiske et al., 2010). According to Dutton (2018), appropriate therapist self-disclosures are paramount for client self-disclosures, and Liddon et al. (2018) found that some clients self-disclose more or less during therapy because of the therapist's gender.

Purpose of the Study

In this study, I examined two types of therapist self-disclosures toward a client and the client's willingness to self-disclose. The purpose of this quantitative research study (Roberts, 2010) was to determine if there are differences between empathetic, factual, and no therapist self-disclosures in terms of a client's willingness to self-disclose. The other purpose was to determine if the therapist's gender is related to a client's willingness to self-disclose. The first independent variable in this study was therapist self-disclosure with three levels (i.e., empathetic, factual, or none). The second independent variable in this study was the gender of the therapist (i.e., male or female). The dependent variable was a client's willingness to self-disclose. This study is unique because it addresses a gap in the research concerning the efficacy of a therapist's type of self-disclosure and the therapist's gender on the client's willingness to self-disclose. Closing this gap will allow for further research in this field, and the results can be implemented by practitioners in the field of clinical psychology to facilitate self-disclosures from their clients (Burkholder et al., 2016).

Research Questions and Hypotheses

RQ1—Quantitative: Is client willingness to self-disclose related to the type of therapist self-disclosure?

H_0: There is no difference in client willingness to self-disclose based on therapist empathetic, factual, or no therapist self-disclosure.

H_1: There is a difference in client willingness to self-disclose based on therapist empathetic, factual, or no therapist self-disclosure.

RQ2—Quantitative: Is client willingness to self-disclose related to the gender of therapist self-disclosure?

H_0: There is no difference in client willingness to self-disclose based on the gender of therapist self-disclosure.

H_1: There is a difference in client willingness to self-disclose based on the gender of therapist self-disclosure.

RQ3—Quantitative: Is client willingness to self-disclose related to the interaction effect between empathetic, factual, or no therapist self-disclosure and the therapist's gender?

H_0: There is no interaction effect in client willingness to self-disclose between empathetic, factual, or no therapist self-disclosures and the therapist's gender.

H_1: There is an interaction effect in client willingness to self-disclose between empathetic, factual, or no therapist self-disclosures and the therapist's gender.

This study had a quantitative research design and involved an attempt to determine the relationship between therapist self-disclosure, no therapist self-disclosure, and the type of therapist self-disclosure (i.e., empathetic or factual) and a client's willingness to self-disclose. Additionally, I sought to determine is whether the gender of the therapist is connected to a client's willingness to self-disclose.

Theoretical Framework for the Study

The theoretical base of this research was social learning theory (Bandura, 1976; Olson & Hergenhahn, 2011; Watkins, 2010) and modeling theory (Bandura, 1965). Psychologists who use social learning theory comingle cognitive and behavioral processes during therapeutic sessions (Bandura, 2001; Walden University, 2010). In other words, therapists help clients examine how they think and its effect on their behavior; conversely, therapists help clients examine their behavior and its effect on how they think.

For psychologists to use social learning theory, they must have clients who are willing to talk about their problems. One way to engage clients to speak about their concerns is to model self-disclosing behavior. According to Bandura (1965), when participants were instructed to play with a Bobo doll in a certain way, the observers tended to imitate those behaviors. Consequently, if a psychologist self-discloses, at the beginning of a session, the client may imitate that behavior and begin to self-disclose also. According to Carew (2009), Beck (2011), Levitt et al. (2015), and Ziv-Beiman et al. (2018), therapist self-disclosures are a way to build the working alliance via modeling behavior by the therapist. In addition, this concept is supported in the Relationship Competency found in the Competency Developmental Levels (DALs) of the National Council of Schools and Programs in Professional Psychology (NCSPP, 2007, pp. 8–15). Beck & Freeman (1990), Walen et al. (1992), and Levitt et al. (2015) used therapist self-disclosures to encourage reciprocity with clients. Continued research and application of social learning theory and modeling theory will facilitate the development of appropriate

therapist self-disclosures that may engender client self-disclosures within the therapeutic relationship.

Nature of the Study

This study had a quantitative research design using the social learning and modeling theory frameworks. It was helpful in determining the relationship between therapist self-disclosure or no therapist self-disclosure, the gender of the therapist, and the type of therapist self-disclosure (i.e., empathetic, factual, or none) and a client's willingness to self-disclose. As the researcher in this study, I surveyed clients who were no longer in therapy concerning their willingness to self-disclose. This design allowed me to determine if there were differences in a client's willingness to self-disclose based on therapist self-disclosure (i.e., factual, empathetic, or none). Also, the gender of the therapist and its connection to a client's willingness to self-disclose was examined. To analyze the relationship between the two independent variables—type of therapist self-disclosure (i.e., factual, empathetic, or none) and gender (i.e., male and female)—and the dependent variable (i.e., client willingness to self-disclose), an analysis of variance (ANOVA) was implemented to analyze the within and between effects of the independent variables on the dependent variable.

Definitions

The following terms are defined and are used throughout this study.

Client self-disclosure: Jourard (1973) defined client self-disclosure as anything the client reveals about him/herself to the therapist, as summarized by Danzer (2019).

Snell et al. (2013) defined client self-disclosure as a client's "willingness to discuss their emotions" (p. 59).

Dependent variable: This variable is what the researcher is trying to explain (Frankfort-Nachmias & Leon-Guerrero, 2015). In this case, it is a client's willingness to self-disclose.

Empathetic self-disclosure: Self-disclosures that show warmth to a client by expressing kind words (Ivey et al., 2014).

Factual self-disclosure: Expresses facts or information about the therapist that are related to the client's problems (Brew & Kottler, 2008).

Independent variable: The independent variable is the variable that is expected to account for the dependent variable (Frankfort-Nachmias & Leon-Guerrero, 2015). For this research, the independent variables were therapist self-disclosure (i.e., empathetic, factual, or none) and the gender of the therapist (i.e., male and female).

Self-disclosure: According to Fiske (2014), self-disclosure is "revealing oneself to another person" (p. 305). Altman and Taylor (1973) defined self-disclosure "as the voluntary communication of feelings, thoughts, or other information deemed to be private and that might make the discloser feel vulnerable" (p. 29). For Collins and Miller (1994), self-disclosure is the "revealing [of] personally relevant experiences, thoughts and feelings to others" (p. 457).

Therapist empathetic self-disclosure: Empathetic disclosures from a therapist involve feelings or emotional statements (Audet, 2011).

Therapist factual self-disclosure: According to Gelso and Palma (2011), therapist self-disclosures are statements by the therapist that refer to “facts or information about the therapist” (p. 343). These self-disclosures are not emotionally based.

Therapist self-disclosure: Lee (2014) quoted Knox and Hill’s (2003) definition of therapist self-disclosure as “therapist verbal statements that reveal something personal about therapists” (p. 530).

Assumptions

There were several assumptions made for this study. One assumption was that therapist self-disclosure is an important part of therapy for many, if not most therapists. Another assumption was that therapist self-disclosure helps establish a link for the client to be willing to self-disclose. It was also assumed that when clients self-disclose, positive therapeutic outcomes occur, and the results will be relevant to other therapists. Last, I assumed that the respondents to the survey would be honest with their answers.

Scope and Delimitations

The scope of this study involved discovering whether there is any connection between the type of therapist self-disclosure (i.e., empathetic, factual, or none) and a client’s willingness to self-disclose. Also, the gender of the therapist was incorporated to determine if there is any connection to a client’s willingness to self-disclose in today’s cultural environment. This research is unique because no one has studied the connections between the type of therapist self-disclosure, the gender of the therapist, and their combined relationship with a client’s willingness to self-disclose.

There were several delimitations included in this study. The age range of the subjects of this study was from 18 to 60. Only respondents who had been in therapy were used because people who have not experienced the therapist–client relationship may not understand the connection between the therapist and the client. Last, people who were mandated by law to seek therapy were also eliminated because mandated clients tend to self-disclose less because of the violations they committed by law (Bitar et al., 2014).

Limitations

All studies have limitations. Because I surveyed only adults for this study, the results may not be generalizable to children. In addition, generalizability to other regions of the United States (e.g., rural areas and cities) and other countries is questionable because this study focused on the tri-state area of New Jersey, New York, and Connecticut. Results will not be generalized to people with drug addictions or people with psychosis. Another limitation in this study was the correlational nature of the data; therefore, no one can draw causal conclusions. Last, some people may have had difficulty understanding the survey. If participants did not understand the directions on the survey, answers might not reflect how they truly felt. Others may not answer the questions honestly.

Significance of the Study

I attempted to close the gap in previous research concerning whether there is a connection between the type of therapist self-disclosure (i.e., factual, empathetic, or none) and the gender of the therapist (i.e., male or female) on the dependent variable (i.e., client willingness to self-disclose). It is essential to induce positive therapeutic outcomes

for the patient no matter what type of therapy; however, it is unclear what kind of therapist self-disclosure will increase client self-disclosure or if the gender of the therapist matters in today's society.

This study can provide positive social change if the results show which type of therapist self-disclosure is connected to increased client self-disclosures. Future therapists can use these findings with their clients to increase client self-disclosures. After all, client self-disclosures tend to enhance positive therapeutic outcomes (Levitt et al., 2015). Last, if the gender of the therapist within today's cultural environment is connected to a client's willingness to self-disclose, then the therapist may gender-match the client (i.e., provide the client a choice of a male or female therapist). If there is no connection between the therapist's gender and a client's willingness to self-disclose, then the therapist's gender will be moot or not relevant for positive therapeutic outcomes.

Summary

The efficacy and appropriateness of therapist self-disclosure to a client has been controversial since Freud (1912/1963) declared it anathema in clinical practice. Over the decades, many studies have been conducted to determine whether therapist self-disclosure is appropriate or effective during sessions. Conversely, few studies have been done on type of therapist self-disclosure and its relationship to client self-disclosure. The type of therapist self-disclosure, such as empathetic or factual comments, may be connected to a client's willingness to self-disclose. Last, the gender of the self-disclosing therapist has been another topic of interest because of the change in American culture concerning gender behavior and stereotypes. More women have been breaking social

stereotypes during the past few decades, and the population of female clinical psychologists has been increasing (Willyard, 2011).

This study will provide the reader with an in-depth review of the literature on therapist self-disclosure and its connection to client self-disclosure. From this study, I plan to close the gap concerning the type of therapist self-disclosure and its connection to a client's self-disclosure and determine if the gender of the therapist is related to client self-disclosure. A current survey was sent to those who had been in therapy, and an ANOVA was employed to analyze the within and between effects of the type of therapist self-disclosure and the gender of the therapist on client self-disclosure.

In the next chapter, I will explore the literature related to the history of therapist self-disclosure, its definition, implementation during therapy and ethical issues, types of therapist self-disclosure, and several contradictions from other researchers in the field of clinical psychology. Also, the gender of the therapist will be explored and its connection to a client's willingness to self-disclose. Last, this exploration will demonstrate the need for this study, which may provide other researchers and therapists the knowledge to apply these findings in order to produce positive social change and improved therapeutic outcomes.

Chapter 2: Literature Review

Introduction

Therapist self-disclosure during a session has long been a controversial issue (Bloomgarden & Mennuti, 2009). The debate for decades has been whether to engage therapist self-disclosures or not (Bundza & Simonson, 1973). For Freud (1912/1963), therapist self-disclosures are anathema for positive therapeutic outcomes for the patient. Freud posited that the relationship between the therapist and client should be purely clinical. He added that the therapist should act "like a mirror, reflect nothing but what is shown" (Freud, 1912/1963, p. 124) and be "devoid of all human sympathy" (p. 121). Freud's approach of "therapeutic neutrality" toward the client became the model of remaining distant from the client (Bloomgarden & Mennuti, 2009, p. 7).

According to Bloomgarden and Mennuti (2009), therapists have begun to break free of Freudian dogma. Literature by Aron (1996), Lee (2014), Levitt et al. (2015), and Wachtel (2008) has demonstrated positive effects of therapist self-disclosures on a patient's willingness to self-disclose. Jourard (1959), who coined the term "self-disclosure," considered therapist self-disclosures to be acceptable and beneficial for the client. In addition, researchers such as Edwards and Murdock (1994), Greenberg and Alanson (1995), and Hansen (2008) have discovered positive effects of therapist self-disclosures on clients, while Watkins (1990) studied counselors' appropriate use of therapist self-disclosures during therapy.

Chapter 2 provides a comprehensive review of the current literature related to therapist self-disclosures and their effect on the elicitation of client self-disclosures.

Furthermore, the type of therapist self-disclosure and the gender of the therapist are examined. In addition, a review of the research questions and social learning theory is provided. Data collection came from the databases at Walden University's library and five core texts. Last, I present a summary of what is known and not known related to therapist self-disclosures and how positive social change will occur by closing a gap in the literature related to therapist self-disclosures and their effect on clients' willingness to self-disclose and positive therapeutic outcomes.

Literature Search Strategy

To better understand therapist self-disclosure, type of therapist self-disclosure (i.e., empathetic or factual), client self-disclosure, and the effect of a therapist's gender on client self-disclosure, a thorough search was conducted using the following databases at the Walden University Library: Academic Search Premier, Google Scholar, ProQuest Articles and Dissertations, PsycINFO, PsycARTICLES, PsycBOOKS, SAGE Journals, SocINDEX, and Taylor and Francis Online. The following keywords were searched: *self-disclosure*, *therapist self-disclosure*, *counselor self-disclosure*, *psychologist self-disclosure*, *therapist immediacy*, *therapist empathetic disclosures*, *therapist factual disclosures*, *positive therapeutic outcomes*, *therapist-client matching*, *therapist gender*, *client gender*, and *client self-disclosure*. Two hundred professional articles were found using the keywords *therapist self-disclosure*, and 279 articles were found using the keywords *therapist gender*. Also, five core texts about therapist self-disclosures, as well as several graduate texts from the Walden Book Store, were used. These graduate psychology texts had a plethora of primary sources to employ. Several seminal sources

were used from the 1960s to the 1980s that were supportive of social learning theory. Peer-reviewed articles as current as 2021 were utilized.

Theoretical Foundation

There are several current psychological theories to support therapist self-disclosure and its effect on the willingness of the client to self-disclose. This research study focused on one significant theory using a quantitative approach (Cooper, 2018; Creswell, 2014). It was social learning theory (Bandura, 1976; Bottrill et al., 2010; Olson & Hergenhahn, 2017; Watkins, 1990), also known as modeling theory (Bandura, 1965, 2001).

Social learning theory was founded by Albert Bandura (Bandura & Walters, 1963; Olson & Hergenhahn, 2017). It is also known as *modeling* or *observational* theory (Olson & Hergenhahn, p. 316). From this point on, the term “social learning theory” will be used instead of “modeling” or “observational theory” to avoid confusion. According to social learning theory, people learn from one another by observing and imitating the behavior of others (Bandura, 1976; Olson & Hergenhahn; Ziv-Beiman et al., 2018). However, Bandura described a distinction between imitation and observation (i.e., observation does not always lead to imitation). For example, a person may observe someone robbing a bank and then call the police. In this case, the person observed the behavior but did not replicate it. Instead, they called the police for help. This phenomenon may be also true within the therapeutic relationship. In other words, the therapist may model therapist self-disclosures during a session, but the client may not reciprocate in turn.

Bandura (1976) posited that this type of learning involves four stages (i.e., *attention*, *retention*, *reproduction*, and *motivation*; Horsburgh & Ippolito, 2018, p. 2). The first stage, *attention*, refers to the learner's attentive skills (p. 2). The learner must be able to remain focused on the behaviors they see (Horsburgh & Ippolito, 2018). Second, the learner must "internalize and *retain* what they have seen" (p. 2). At this stage, the learner must be able to use cognitive processes to rehearse the required behavior (Horsburgh & Ippolito, 2018; Olson & Hergenhahn, 2017). These cognitive processes include visuals, also known as a *cognitive map* (Olson & Hergenhahn, p. 320). Tolman (1948) was the first to create the term and defined the cognitive map as a mental picture of an experience. Bandura (1986) defined the cognitive map as a mental image. The third stage involves the *reproduction* of the observed behavior and the practice needed to perfect the appropriate behavior (Horsburgh & Ippolito, 2018, p. 2; Olson & Hergenhahn). The final stage occurs when the observer is *motivated* to reproduce the behavior (Horsburgh & Ippolito, 2018, p. 2). Because memory is an integral part of the processing of data, cognitive psychologists study the encoding and retrieval of information stored in memory (Cacioppo & Freberg, 2017, p. 339; Laureate Education, 2012).

Bandura (1976) proposed that reinforcement is needed for motivation and reproduction of observed behavior to occur. Bandura's (1965) classic *Bobo doll* experiment demonstrated that children who observed a person receiving positive reinforcement while beating up a doll tended to imitate the behavior of adults who were aggressive with the doll (p. 590). This type of reinforcement is known as *vicarious reinforcement* (i.e., the reinforcement is observed and not given directly to the learner;

Olson & Hergenhahn, 2017, p. 317). Bandura (1976) clarified his position on reinforcement and learning. He stated that learning occurs all of the time via cognitive processes, and when the learner receives reinforcement, the behavior is performed (Olson & Hergenhahn, p. 317). Consequently, when the therapist self-discloses, the client observes this behavior. Then the client reciprocates the behavior being modeled by self-disclosing their problems. Bandura (1986) called this process *reciprocal determinism*. In other words, when a client observes a therapist disclose, the client learns the behavior and self-discloses, which improves the therapeutic relationship (Bach, 2017; Brauer & Tittle, 2012; Castonguay et al., 2018; Radulescu et al., 2016).

Bach (2017) and Murphy et al. (2016) discussed the approach/avoidance conflict that can occur during therapeutic sessions (i.e., the approach variable is connected with positive reinforcement, while the avoidance variable is connected with negative reinforcement). Many clients may not self-disclose because they may fear being stigmatized by the therapist. Bach (2017) called this situation “passive avoidance and behavioral inhibition” (p. 18). In order for a therapist to help a client self-disclose, the therapist must provide an appropriate self-disclosure as a model for the client to replicate. As the client replicates the self-disclosure behavior of the therapist, the self-disclosure of the client becomes self-reinforcing (Bach, 2017).

Brauer and Tittle (2012) added that social learning theory supports the concept of differential reinforcement. Differential reinforcement is the implementation of reinforcing only the behaviors one wants to elicit from clients (Brauer & Tittle, 2012). When the client self-discloses, the therapist will reinforce that behavior by providing an

appropriate response in turn (Trump et al., 2019). For Trump et al. (2019), the therapist must actively reinforce the self-disclosure behavior of the client in order for the client to continue to help the therapist identify and treat the problem. Radulescu et al. (2016) added that the therapist must engage in selective attention when the client self-discloses in order to help the client focus on their presenting problem. If the client is not reinforced for producing a self-disclosure, the client may stop the discussion and terminate.

Social learning theory played an important role in this study. Social learning theory has a history of use by psychologists in the field of psychotherapy (Cacioppo & Freberg, 2017). Psychologists who use social learning theory model appropriate self-disclosure in order to elicit client self-disclosure during therapeutic sessions (Bandura, 2001; Beck, 2011a, 2011b; Walden University, 2010). In other words, therapists help clients to self-disclose by experiencing (i.e., observing) the therapist's self-disclosure, as supported by Knox and Hill (2003). After all, clients who self-disclose tend to reduce their reported symptoms (Hill et al., 2018).

Furthermore, social learning theory was relevant to the research questions in this study (i.e., therapist self-disclosure, type of therapist disclosure, the gender of the therapist, and client self-disclosure). In order for clients to discuss their problems, a therapeutic relationship must be developed, as is supported in the Relationship Competency found in the Competency Developmental Levels (DALs) of the National Council of Schools and Programs in Professional Psychology (NCSPP, 2007, pp. 8–15). Beck & Freeman (1990), Levitt et al. (2015), Priebe et al., 2014, and Walen et al. (1992) used therapist self-disclosures to encourage reciprocity with clients. The therapist

develops this relationship with appropriate self-disclosures during a session. Positive social change is advanced if the therapist can increase client self-disclosure, which elicits improved therapeutic outcomes for the client (Hill et al., 2018; Levitt, 2015; Walden University, 2015).

Literature Review Related to Key Variables and/or Concepts

In this section, I examine the effects of therapist self-disclosure, the type of therapist self-disclosure, and the gender of the therapist on client self-disclosure, as well as positive therapeutic results for the client. For decades, there has been much controversy concerning therapist self-disclosure during a counseling session toward the client (Henretty & Levitt, 2010; LaPorte et al., 2010), yet there is increasing evidence of therapist self-disclosures having a positive effect on therapy for the client (Knox & Hill, 2003; Lee, 2014; Levitt et al., 2015). There is also current, yet a paucity amount of research on the type of therapist self-disclosure that was examined and its effect on client self-disclosure (Lee, 2014). In addition, many studies have examined whether the gender of the therapist will induce client self-disclosures (Janusz et al., 2018). Last, Dazkir and Read (2012) discovered that client self-disclosure facilitates positive therapeutic outcomes for the patient. Hill et al. (2018) echoed the findings of Dazkir and Read.

Therapist Self-Disclosure

Lee (2014) quoted Knox and Hill's (2003) definition of therapist self-disclosure as "therapist verbal statements that reveal something personal about therapists" (p. 530). Bitar et al. (2014) considered therapist self-disclosure as an expression of authenticity, and Bottrill et al. (2010) defined it more generally as a therapist behavior. Bitar et al.

added that it is a clinical intervention skill, while Audet (2011) called it a form of boundary-crossing. Lee discovered Hill and Knox's (2001) other enumerated forms of therapist self-disclosure, such as body language, sitting position, clothing, family photos on the desk, and expressed values. Danzer (2019) posited that all therapists self-disclose intentionally and unintentionally and must be willing to explore this phenomenon further.

According to Lee (2014), therapist self-disclosure also reveals unintentional personal aspects of the therapist via the therapist's appearance, attire, and statements. Examples include the type of hairstyle, makeup, body weight, skin color, pregnancy, tattoos, and jewelry. Also, attire reveals the therapist's taste, economic status, formality or informality, as well as how therapists wear their clothes (i.e., well-fitted, ironed, or unkempt; Carneiro et al., 2013). Last, some academics distinguish between "self-disclosing and self-involving statements" (Lee, p. 16). *Self-disclosing statements* by the therapist refer to "facts or information about the therapist" (Gelso & Palma, 2011, p. 343), which may not be related to the client's problems and are distractive, while *self-involving statements* refer to the therapist's "immediate or past feelings or experiences in response to the patient's experiences or feelings" (p. 343), which are considered relevant and helpful for the client.

Some psychologists such as Bitar et al. (2014), Bottrill et al. (2010), and Audet and Everall (2010) have contended that therapist self-disclosure is an intentional clinical intervention skill involving genuineness. First, Bitar et al. discovered that when therapists self-disclose appropriately, the therapeutic alliance is strengthened by "normalizing client problems, lessening the therapist–client hierarchy, and modeling the acceptability of self-

disclosure" (p. 417). These findings were based on feedback from clients who received therapist self-disclosures during the course of therapy (Bitar et al., 2014). Second, the clients perceived the therapist as being more human and similar to themselves during the early stages of therapy (Audet & Everall, 2010; Bitar et al.).

Levitt et al. (2015) discovered that it was not the number of therapist self-disclosures that increased the client's self-disclosures and alliance score, but rather therapist self-disclosures that were similar to the client's problems were more efficacious for producing positive therapeutic outcomes. Also, Levitt et al. discovered that therapist self-disclosures that humanized the therapist were connected with fewer clinical symptoms later during therapy. Last, neutral therapist self-disclosures were correlated with improved client functioning more than negative or positive information about the therapist. As a therapist, one must be aware of how much therapist self-disclosure is appropriate with the client (LaPorte et al., 2010). Too much therapist self-disclosure may cause the client to question the therapist's boundaries, while too little therapist self-disclosure may make the client feel marginalized (Danzer, 2019).

Lee (2014) discovered that it is important for therapists to understand a client's culture before self-disclosing their world views, which may not be in tandem with their clients. Bitar et al. (2014) discovered that when therapists understood a client's culture, they formed and elicited more appropriate therapist self-disclosures, which in turn improved the therapeutic relationship. Furthermore, Bitar et al. found that the therapist was perceived as more human, and the clients felt that they were not alone with their problems. Larson and Bradshaw (2017) found evidence that culturally competent

therapists improved therapeutic outcomes as clients self-disclosed more. Similarly, when therapists are culturally competent, they know how and when to deliver self-disclosures that reflect the client's culture. Consequently, the type of therapist self-disclosure must be related to the client's issues.

Type of Therapist Self-Disclosure

An area of needed study is whether a specific type of therapist self-disclosure (i.e., empathetic or factual) has a positive or negative effect on the number of self-disclosures from clients. Lee (2014) noted that there is a need for further study concerning what type of therapist self-disclosures engage rather than disengage the client to self-disclose. Hill et al. (2018) added that there is a need for "empirical evidence about therapist self-disclosure" (p. 445) and therapists' efficacy to engage a client to self-disclose. Also, Pinto-Coelho et al. (2018) found a plethora of therapist self-disclosures that were unsuccessful in eliciting client self-disclosure. Consequently, psychologists and psychotherapists do not know what types of self-disclosures by therapists will elicit self-disclosures by clients.

My study focused on therapist self-disclosure and its effect on a client's willingness to self-disclose. The following types of therapist self-disclosures were examined: (a) empathetic therapist self-disclosure and (b) factual therapist self-disclosure. This study determined whether there is any difference in a client's willingness to self-disclose when a therapist engages in empathetic or factual types of self-disclosure, as well as no therapist self-disclosure. It will close a gap in the literature related to the type of therapist self-disclosure and its effect on a client's willingness to self-disclose. It

is also important to note the effects of no therapist self-disclosures on a client's willingness to self-disclose as a condition for comparison in my study. Also, most current empirical studies support therapist self-disclosure over non-therapist self-disclosure (Lee, 2014; Paine et al., 2010), and Henretty and Levitt (2010) found that "self-disclosing therapists elicited more positive responses and perceptions from clients than therapists who did not disclose" (p. 69). Closing this gap will help other therapists to decide when to use empathetic, factual, or no self-disclosures during therapy with a client, which historically has been a concern within the psychological therapeutic community.

History of Therapist Self-Disclosure

This recent change in acceptance of therapist self-disclosure as a clinical variable during therapy was not allowed during Freud's time. Freud (1912/1963) advocated that the therapeutic model should be purely clinical, and the therapist must maintain a distant relationship with the client (Bitar et al., 2014; Bloomgarden & Mennuti, 2009). However, it is a fact that even Freud self-disclosed (i.e., his gender, age, and physical appearance) (Farber, 2006) and at times, struggled to keep his aloof approach toward the client (Kilborne, 2008). Danzer (2019) and Audet (2011) stated that intentional therapist self-disclosure is a common practice. Concerning multiple studies, 65-90% of therapists who were surveyed admitted to intentionally self-disclosing to clients (Audet; Henretty & Levitt, 2010; LaPorte et al., 2010). According to Danzer, therapist self-disclosure, whether intentional or not, exposes the human side of the therapist which in turn improves the therapeutic relationship. It is evident that therapists do self-disclose.

Over many decades, the professional, therapeutic relationship between the therapist and client has evolved (Danzer, 2019). Jourard (1959) struggled as a therapist while developing a therapeutic relationship with his patients. He discovered that when he self-disclosed, his clients opened up to him more. He coined the term “self-disclosure” (Jourard, 1973), and his work on therapist self-disclosures was embraced by other schools of psychology (Danzer, 2019). Jourard posited that therapist self-disclosures helped clients to open up and share more (Henretty & Levitt, 2010).

During the past decade, therapist self-disclosure has received more attention in theoretical debates (Danzer, 2019), empirical research (Bitar et al., 2014), and within many mental health persuasions (D’Aniello & Nguyen, 2017). There was even controversy over the meaning of therapist self-disclosure (Danzer; Henretty & Levitt, 2010), whether it was a therapist behavior or not (Bottrill et al., 2010), the amount of therapist self-disclosure (LaPorte et al., 2010), and ethical issues concerning its use during therapy (Audet, 2011; Henretty & Levitt).

Theoretical Perspectives

Psychological studies over the decades on therapist self-disclosure have provided clinicians with a multitude of opportunities to better understand the effects of therapist self-disclosure on client self-disclosure. Even though this research did not provide a model that was most effective in producing client self-disclosure (Danzer, 2019), it is important to consider these orientations because there is a diversity of therapists who may use this information to determine the type and frequency of therapist self-disclosure and their impact on client self-disclosure (Ackerman & Hilsenroth, 2003; Audet & Everall,

2003). Last, to read about different theoretical points of view can guide therapists who decide to self-disclose, the type of self-disclosure to engage, and when to self-disclose to the client (Danzer).

Before the late 1950s, psychoanalytic models discouraged therapist self-disclosure completely (Bitar et al., 2014). Henretty and Levitt (2010) found that most traditional psychologists were trained to avoid therapist self-disclosure because it could promulgate transference. Bottrill et al. (2010) discovered that even though Freud postulated that therapist self-disclosure to the client was anathema for clinical work, he revealed personal aspects of his life to his clients. One must wonder whether self-disclosure is a natural phenomenon.

During the 1960s, when the civil rights movement burgeoned with an increase in egalitarianism, liberal therapists developed and encouraged mild forms of therapist self-disclosure (Bitar et al., 2014). This notion was based on the conceptualization of the therapeutic relationship as a functioning dyad during the course of therapy (i.e., therapist and patient worked as a team) (Bitar et al.; Tsai et al., 2010). It was Sidney Jourard in 1958, as a humanist therapist, who discovered that therapist self-disclosure helped clients to "reveal more about themselves and participate more authentically in therapy" (Danzer, 2019, p. 16). During this time, client-centered and existential schools of psychology were open to therapist self-disclosure as a way to humanize the therapeutic relationship while modeling transparency, authenticity, and reciprocity (Audet, 2011; Bottrill et al, 2010; Dean, 2010; Henretty & Levitt).

During the late 60s and early 70s, self-psychology developed by Heinz Kohut (1971) espoused the use of empathy and validation during therapy. He and his fellow psychologists used therapist self-disclosures only when they were well-planned so that the therapist could understand the client "from within – from his own unique perspective" (Afek, 2019, p. 166). His idea as a psychologist was to explore the self and how it developed from experiences while growing up. For the client to understand him/herself, he/she must be able to self-disclose his/her experiences. Consequently, psychologists in the school of self-psychology used therapist self-disclosures judiciously to stimulate reciprocal client self-disclosure (Danzer, 2019).

The cognitive-behavioral theory of therapist self-disclosure during the 60s to the present has stressed its use only as an intervention tool within the confines of a treatment plan (i.e., an agreed-upon step-by-step process for the client to attain the desirable outcome from therapy) (Danzer, 2019). By using a treatment plan, cognitive-behavioral psychologists measure the effectiveness of therapist self-disclosure on client self-disclosure and client therapeutic outcomes (Danzer). These therapists use therapist self-disclosure to challenge a client's negative perception of his/her life events (Danzer). A therapist does this by specifically revealing examples to the patient how he/she had coped with life events to serve as a model for the client to follow (Bottrill et al., 2010). A survey of cognitive-behavioral therapists conducted by Miller and McNaught (2016) echoed the findings of Bottrill et al. In addition, these cognitive-behavioral therapists used therapist self-disclosures only as an intervention technique when their clients presented a cycle of negative feelings, thoughts, and behavior (Miller & McNaught).

Cognitive-behavioral psychologists are open to intentional therapist self-disclosures when there is “a clear clinical purpose and relationship to identified treatment goals” (Danzer, 2019, p. 17). These psychologists also reported that they would decide whether to use therapist self-disclosure depending on what was being discussed during the session with the client as an intervention technique to help the client recognize and control his/her cycles of emotions, cognitions, and behavioral responses (Miller & McNaught, 2016). For example, if a client shared a problem that was a continuous cycle of irrational thinking or self-defeating behavior, the cognitive-behavioral psychologist would reflect on his/her own experience and share with the client how he/she navigated the problem (Danzer).

Experiential therapy also incorporates intentional therapist self-disclosure (D’Aniello & Nguyen, 2017). Experiential approaches in therapy focus on the client’s “current feelings, perceptions, and bodily sensations and emphasize the formation of an accepting person-to-person relationship between client and therapist” (Greenberg et al., 1989, p. 169). Experiential therapists use expressive activities (i.e., role-playing of past experiences of the client so he/she can identify and learn to cope with these feelings in the here and now). According to D’Aniello and Nguyen’s review of Carl Whitaker’s therapist self-disclosure technique, the therapist must be able to engage in self-disclosures that represent vulnerability to help the client self-disclose vulnerability. Carl Whitaker was a family therapist who created experiential therapy during the 1950s (D’Aniello & Nguyen; Whitaker, 1973; Whitaker, 1976). He believed that it was unfair for the client to be vulnerable while the therapist remained protected (Whitaker). Experiential therapists

such as Carl Whitaker believed that therapists must use therapist self-disclosure that relates to the client's issues as a technique to help the client develop an appreciation for exploring the "client's ongoing stream of awareness" (Greenberg et al.,1989, p. 170). Reciprocity in the therapeutic relationship is important when engaging any client (Danzer, 2019), and Whitaker did this by modeling vulnerability via therapist self-disclosure (D'Aniello & Nguyen, 2017).

Michael White was the founder of narrative family therapy (Carr, 1998; D'Aniello & Nguyen, 2017; White, 2009). Narrative family therapy helps clients to separate their problems from their identity via the stories they tell. He believes that clients are the experts and have much to share about the meaning they give to their experiences. White is a proponent of therapist interventions that are from the therapist's own life (i.e., therapist self-disclosure), and they are applied during sessions when appropriate to help clients externalize their problems from their own identities (D'Aniello & Nguyen).

Last, feminist psychologists engage tactful (Tabol & Walker, 2008) and proactive forms of therapist self-disclosures related to personal, social beliefs, and political ideology (Audet, 2011; Bitar et al., 2014; Bottrill et al., 2010). In essence, feminist psychologists self-disclose to mitigate the therapist/client power disparity, establish a healthy professional relationship, and allow the client to make better-informed decisions when selecting a therapist or when making life-altering decisions independently from the therapist and others outside of therapy (Audet; Bitar et al.; Bottrill et al.). According to the feminist model, clients are allowed to ask for therapist self-disclosure (Dean, 2010)

which encourages the client to view the therapist as open and distinct. This perception by the client then increases client individuation and liberation from a therapist/client power relationship, as well as decreases dependency on the therapist (Thomas, 2008). After all, psychotherapy is supposed to help clients become more free-thinking and better able to recognize their triggers and then alter their behaviors on their own.

Modern psychodynamic schools are more open to therapist self-disclosure as a way to elicit client self-disclosure and reciprocity during therapy (Audet, 2011; Bottrill et al., 2010; Ziv-Beiman & Shahar, 2016); albeit, they caution its use because of tainting the transference, counter-transference, and providing clients with inappropriate therapist self-disclosures simply to gratify their curiosity about the therapist (Audet; D'Aniello & Nguyen, 2017). Early traditional therapists' reluctance to use therapist self-disclosure has been taken seriously by many modern psychologists because of the potential to cause ethical boundary violations (Bitar et al., 2014). All therapists must adhere to the *American Psychological Association Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2010) and avoid boundary-crossing when engaging in therapist self-disclosure.

Since the time of Freud, therapist self-disclosure and its use have evolved significantly over the decades and within the different fields of psychotherapy. Freud (1912/1963) disavowed any form of therapist self-disclosure (Bloomgarden & Mennuti, 2009; Drescher, 2013), yet he self-disclosed too and revealed personal aspects of his life (Bottrill et al.). As new psychologists began to practice psychotherapy, they developed a new attitude toward therapist self-disclosure and discovered its positive effects on the

therapeutic relationship with the client (Audet, 2011; Danzer, 2019). Conversely, D'Aniello and Nguyen (2017) warned of its potential negative effects (i.e., the blurring of therapeutic boundaries). When therapists decide to self-disclose, they must consider the code of ethics within the profession (D'Aniello & Nguyen; Danzer).

Therapist Self-Disclosure and Ethical Principles

Although the *American Psychological Association Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2010) does not directly address therapist self-disclosure, it does address it related to other issues. According to Knapp et al. (2015), ethical issues related to therapist self-disclosure fall under boundary issues within the *General Principle A: Beneficence and Nonmaleficence* of the *American Psychological Association Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association). Knapp et al. suggest that boundary-crossing via limited therapist self-disclosure may not be inherently unethical, and on occasion, they may be clinically needed to help the client. For example, a therapist's male patient offers the therapist a good deal on a television set from where he works. The therapist does not want to offend the client and possibly ruin the therapeutic relationship. The therapist could quote *Standard 3.08: Exploitive Relationships* (American Psychological Association, p. 9), and tell the client that therapists are not allowed to engage in this type of transaction. The therapist could also self-disclose that he/she has a television that is working well as another option, which would maintain *Principle A: Beneficence and Nonmaleficence* (American Psychological Association, p. 3). Ringel (2002) discovered that some self-disclosure from the therapist can help build trust with

clients, and the therapist must be careful to adhere to *Principle A: Beneficence and Nonmaleficence* (American Psychological Association, 2010, p. 3) and avoid self-interest during therapy which is at tandem with *Standard 3.05, Multiple Relationships* (American Psychological Association, p. 8). If the therapist accepted the television deal, then this action by the therapist would be an example of self-interest over the client's needs. In other words, the therapist must also be mindful as to whether the self-disclosure is serving the needs of the therapist more than the client (D'Aniello & Nguyen, 2017; Farber, 2006).

Considerations When Using Therapist Self-Disclosure

Zur (2010) maintains that a therapist must consider beforehand whether the therapist's self-disclosure is in the best interest of the client and not a form of self-admiration (i.e., personal accomplishments by the therapist to the client). If the therapist is gaining personal satisfaction describing his/her professional awards or accomplishments during therapy, then a form of boundary-crossing or violation may occur (D'Aniello & Nguyen, 2017). This behavior by the therapist falls under *Principle A: Beneficence and Nonmaleficence* (American Psychological Association, p. 3) and may do more harm than good for the client. In addition, the therapist must consider the client's history of personal relationships before engaging in therapist self-disclosure (Ziv-Beiman & Shahar, 2016) because the client may question the motives of the therapist if the client has had a history of disclosures from others that were harmful (D'Aniello & Nguyen). Because of the inherently personal nature of therapist self-disclosure with a client, it is

paramount for the therapist to continuously question why he/she would self-disclose to a client.

Therapists must be careful to avoid any form of boundary-crossing with a client when self-disclosing to avoid possible harm to the client. Consequently, therapists must discuss their motivations to a supervisor or peer to discover if their self-disclosures are related to earlier life experiences being triggered by the client's self-disclosures (D'Aniello & Nguyen, 2017). These types of therapist self-disclosures could violate *Standard 2.06, Personal Problems and Conflicts* (American Psychological Association, 2010, p. 7) and could lead to a violation of *Standard 3.05, Multiple Relationships* (American Psychological Association, p. 8) (i.e., a role reversal whereby the client counsels the therapist). D'Aniello and Nguyen highly recommend that therapists seek supervision when they continuously feel the need to self-disclose to the client and develop appropriate measures to avoid too many and/or inappropriate therapist self-disclosures.

Factors to Consider Before Engaging in Therapist Self-Disclosure

Current literature provides additional guidelines for therapists as to the appropriate use of therapist self-disclosure during a session. According to Dean (2010), the therapist must consider the personality of the client, as well as the presenting symptomology. Consequently, the therapist must build a therapeutic relationship first (Danzer, 2019). Also, clinicians must consider the goals of self-disclosure and appropriate wording toward the client during a session (D'Aniello & Nguyen, 2017; LaPorte et al., 2010; Sturges, 2012). Dean suggested that therapists use self-disclosure

infrequently, and Bottrill et al. (2010) and Henretty and Levitt (2010) stated that the therapist's self-disclosure should be brief and relevant to the client's problems. Conversely, too much therapist self-disclosure and lack of relevance to the client's experiences could place the therapist's self-interest over the primary interest of the client (D'Aniello & Nguyen, 2017).

Factors to Consider After Engaging in Therapist Self-Disclosure

It is also important to follow up with a client after a therapist makes a self-disclosure to a client. After disclosing to a client, the therapist must immediately return to the therapeutic process with the client (Sturges, 2012). Sturges recommends asking the client about how he or she felt when the self-disclosure was made and then make appropriate adjustments such as no self-disclosures, less self-disclosures, or more specific and related self-disclosures toward the client. According to Henretty and Levitt (2010), this process reinforces appropriate roles during the therapeutic session and improves productive therapeutic work (Vandenberghe & Silva Silvestre, 2014).

When clients react negatively to a therapist's self-disclosure, it is important to fully explore their reactions (Ziv-Beiman & Shahar, 2016). Ziv-Beiman and Shahar suggested that the therapist immediately repair the therapeutic rupture by acknowledging the mistake and determine with the client whether or not to continue to engage in therapist self-disclosure or type thereof. The therapist must also review the clinical process for the client and seek supervision to improve the therapeutic relationship (Danzer, 2019; Ziv-Beiman & Shahar).

The therapist needs to make therapist self-disclosures to the client based on the client's personality, reported problem, and culture the client comes from. Also, the therapist must consider the best interests of the client according to the *American Psychological Association Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2010). The therapist needs to consider the type, frequency, and intimacy of the therapist self-disclosures during the course of the sessions (Danzer, 2019).

Functions of Therapist Self-Disclosure

According to Lee (2014), there are three functions of therapist self-disclosure in therapy. They are the: a) development of a positive therapeutic relationship with the client during the early phases of therapy, b) conveyance of a genuine, empathic, transparent, attentive, and responsive therapist toward the client, and c) engagement of relevant therapy (e.g., reassuring the client throughout the therapeutic process; Audet, 2011; Gibson, 2012; Taddicken, 2014). Respectively, if the therapist gives too little, too much, or self-serving self-disclosures within the first several sessions, the client may leave. When the therapist shows genuineness and empathy via self-disclosures, the client will perceive the therapist as human and similar to him/herself. Last, when the therapist elicits relevant self-disclosures, the client is reassured that the therapist is understanding the presenting problems. Thus, therapist self-disclosure facilitates positive therapeutic outcomes for the client (Lee), and it is paramount for the therapist to form a positive working relationship with the client during the first few sessions using appropriate and relevant therapist self-disclosures (Audet & Everall, 2010; Bitar et al., 2014; Lee; Marks

et al., 2018). Also, Pinto-Coelho et al. (2016) found that doctoral students reported that the therapeutic relationship was stronger when therapists self-disclosed empathetic versus factual self-disclosures. Lee has acknowledged a quote from Norcross (2002) that therapist self-disclosure has become a “promising element” within the therapeutic process (p. 464).

Client Self-Disclosure

Client self-disclosure is something the client reveals about him/herself (Fiske, 2014; Fiske et al. 2010). Fiske stated that self-disclosure is “revealing oneself to another person” (p. 305). Client self-disclosure began with Freud (Freud, 1966/1912) who encouraged clients to talk about their problems (Henretty & Levitt, 2010). Jourard (1973) defined client self-disclosure as anything the client reveals about him/herself to the therapist (Danzer, 2019). Snell et al. (2013) defined client self-disclosure as a “willingness to discuss their emotions” (p. 59). Melumad and Meyer (2020) added that Altman and Taylor’s (1973) definition of self-disclosure “as the voluntary communication of feelings, thoughts, or other information deemed to be private and that might make the discloser feel vulnerable” (p. 29). Therapists from all psychological orientations use therapist self-disclosure to help their clients resolve their self-disclosed issues (Danzer; Lee, 2014; Joinson, 2003). The goal of therapy is to help clients resolve their problems via their willingness to self-disclose in a private setting (American Psychological Association, 2010; Audet & Everall, 2010; NCSPP, 2007).

Client Willingness to Self-Disclose

Client willingness to self-disclose is an area in need of study. Jeske et al. (2019) described willingness to self-disclose as “the tendency of individuals to be more or less willing to share sensitive information about themselves with others” (p. 100). Sensitive information may include the client’s sexuality, sexual behaviors, religious beliefs, illegal activity, or idiosyncratic behaviors (Jeske et al.). If the client is not willing to self-disclose, then therapy cannot continue effectively (Danzer, 2019). No therapist can force a client to self-disclose. Consequently, the therapist must know several factors that generate client willingness to self-disclose.

Factors That Engender Client Willingness to Self-Disclose

Melumad and Meyer (2020) discovered that people tend to self-disclose when they feel the social environment is private (i.e., what is revealed will not be shared). According to Standard 4., *Privacy and Confidentiality*, found in the *American Psychological Association Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2010, p. 7), the therapist must safeguard the confidentiality of the client. This protection is completed via Standard 3.10, *Informed Consent* (p. 7) which outlines all counseling procedures in written form. The therapist must also discuss the limits of confidentiality according to Standard 4.02, *Discussing the Limits of Confidentiality* (American Psychological Association, p. 7). The psychologist has the responsibility to clearly explain to the client this standard and ensure that he/she will do everything possible to maintain the client’s privacy. Psychologists must additionally discuss when they are required to disclose information about a client

according to Standard 4.05, *Disclosures*, (American Psychological Association, 2010, p. 8), such as when the client states he/she may harm him/herself or others. John et al. (2011) added that clients will self-disclose when there is a reduction of “disclosure danger" (i.e., a fear that what they disclose will cause a negative outcome) (p. 860). A client may fear being marginalized by the family, co-workers, or losing a job if his/her disclosures are released to the public. Kim and Kim (2018) echoed the findings of John et al. concerning a client’s intimate information. Therapists can reduce this fear by discussing all possible means and limitations of protecting the client’s privacy. Consequently, the client can then make rational choices about what is to be disclosed to the therapist before the therapy process begins. John et al. have called this process “disclosure management” (p. 859).

Client willingness to self-disclose is also influenced by what the client is asked or has to talk about and if the therapist self-discloses information related to the client’s issues (Danzer, 2019; Højgaard & Laursen, 2017). Henretty et al. (2014) found that when the therapist’s self-disclosures were related to the client’s problems, the client was more willing to self-disclose to the therapist. Furthermore, Corrigan and Rao (2012) discovered that clients tend to reduce self-disclosures concerning issues they perceive to be stigmatized and self-disclose more when the issues are not stigmatized by society. This perception of stigma becomes internalized, and the client engages in behaviors connected to the stigmatized issue. Corrigan and Rao called this process “self-stigma” (p. 464). Lucksted et al. (2011) analyzed the group intervention technique known as “Ending Self-Stigma” (p. 51) and found it to be effective in reducing a client’s internalized stigma.

Consequently, the reduction in client self-stigma increased client willingness to self-disclose (Lucksted et al., 2011). Seidman et al. (2018) echoed the work of Lucksted et al. via the use of self-affirmation interventions which significantly reduced a client's self-stigma and increased client willingness to self-disclose. Reavley and Jorm (2014) also established that clients were more willing to self-disclose when they perceived their issues were not stigmatized by society.

Another variable that increases a client to self-disclose is his/her relationship with the therapist. Corrigan and Rao (2012) stated that clients must be given a sense of empowerment by the therapist. When Corrigan and Rao provided therapist self-disclosures that supported their clients, the clients self-disclosed more. Forrest (2012) added that when the client trusts the therapist, he/she was more willing to self-disclose. Forrest also discovered via post interviews with clients that when therapists showed genuineness and empathy, their clients provided more honest self-disclosures which in turn, reduced their reported symptoms. Levitt et al. (2015) added that clients liked their therapists when the therapist self-disclosed. These therapists were seen as more human and caring which led to an increase in client self-disclosures (Levitt et al.). Henretty et al. (2014) established a strong positive correlation between therapist self-disclosures that were related to the client, client trust of the therapist, and the client's willingness to self-disclose. Consequently, the positive therapeutic relationship between the therapist and the client is important for the procurement of client self-disclosure.

Therapist's Gender

Client willingness to self-disclose may be affected by the gender of the therapist. Research on the effects of a therapist's gender on a client's willingness to self-disclose has been on-going for several decades (Danzer, 2019; Staczan et al., 2017). Henretty and Levitt (2010) have analyzed 30 studies that were conducted from 1974 to 2007 concerning therapist gender and found no significant relationship between a therapist's gender and his/her self-disclosure impact on client self-disclosure. However, our society has changed significantly within the past decade (Fiske, 2014). Our folkways (i.e., common courtesies), mores (i.e., morals), laws, values, sanctions, and gender roles have been shaped by our current culture in America and have changed significantly (Fiske; Fiske et al., 2010). What we do not know is whether male or female therapists will engender more self-disclosures from clients in America's current diversified culture. Consequently, the gender of the therapist is an essential variable since some clients may prefer one gender to the other and may self-disclose more or less during therapy based on the therapist's gender (Liddon et al., 2018).

Effects of a Therapist's Gender on Client Willingness to Self-Disclose

Staczan et al. found that male and female clients were more willing to self-disclose when female therapists self-disclosed than male therapists who self-disclosed. When female therapists were matched with female clients, female therapists who self-disclosed elicited more client self-disclosures from female clients than male clients (Bhati, 2014; Staczan et al.). Staczan et al. concluded that female clients preferred female therapists while male clients were indifferent toward the gender of the therapist. These

preferences may be related to a client's willingness to self-disclose to the therapist based on the therapist's gender (Staczan et al., 2017). One exception occurred when male clients needed to discuss erectile dysfunction. Most male clients were more willing to self-disclose to female therapists than male therapists because sexual dysfunction is perceived to be a weakness among males, thus making it difficult to talk to a male therapist (Staczan et al.). Another exception occurred when clients were willing to talk more to a female therapist than a male therapist when their symptoms were more severe, thus adding severity of symptoms to be a moderating variable (Staczan et al.). Staczan et al. found that female therapists tended to elicit more empathic self-disclosures than male therapists which caused clients to self-disclose more to female therapists. Danzer (2019) and Fiske (2014) added that the client may self-disclose more or less based on the gender role of the therapist (i.e., the behavior manifested by society specific to the gender of the therapist).

Gender Role of the Therapist

Barbeau (2019) defined the gender role of a therapist as the behavior related to the therapist's gender. According to Fiske et al. (2010), gender roles are the behaviors expected of men and women within a particular culture and generation. From early childhood, these roles based on gender become part of the belief system of those who are observing the behavior, and these gender roles develop from the division of labor in society (Fiske et al.). For example, in some cultures, women may be perceived as compassionate, giving, and demure and men as tough and aggressive. Fiske et al. added that men tend to be "agentic" (p. 632), while women tend to be "communal" (p. 632).

This means that men are assertive, competitive, and domineering and women are friendly, unselfish, and care about others, respectively. Staczan et al. (2017) have found that female therapists tend to be “more emotion-oriented, more empathic, than their male counterparts” (p. 75). Conversely, most patients viewed male therapists as more “direct and problem-focused” than female therapists (Staczan et al., p. 75). In addition, female therapists used significantly more interventions that were empathetic or supportive when their patients were female than male. Consequently, the gender role of the therapist which develops from his/her sociocultural upbringing may surface during therapy and may increase or decrease the client’s willingness to self-disclose (Barbeau, 2019; Fiske et al., 2010).

Gender Role of the Therapist and the Culture of the Institution. The gender role of the therapist can be determined by the culture of an institution where a therapist works. Barbeau provided an example of how a male therapist versus a female therapist operated in a female correctional facility that had a culture of systemic sexism displayed by the male guards. Barbeau noted that in this case, male privilege in this facility would facilitate the perception that a male therapist’s self-disclosure to a client would be a sign of strength, while for the female therapist, it would be seen as a sign of weakness from the client’s point of view. In other words, if the gender of the therapist is not respected, his/her self-disclosures toward a client may have no effect or a negative effect on a client’s willingness to self-disclose. Barbeau’s observations were proven to be correct in this particular case. The male therapist was able to earn the trust of the female client by

avoiding sexist self-disclosures, and the client was willing to self-disclose more (Barbeau, 2019).

Family-of-Origin Issues and Gender Role of the Therapist. Therapists must also consider their family-of-origin experiences related to their gender and therapist self-disclosure. Consequently, the nature of the therapist's relationship with his/her parents and siblings can influence the gender role behavior of the therapist (i.e., the therapist may act as a father/mother/brother/sister figure toward the client using related self-disclosure; Barbeau, 2019). Similarly, the therapist may counter-transfer his/her gender relationship learned from the family-of-origin via stereotypical self-disclosures to the client. When the therapist is aware of his/her gender role and the stereotypical behaviors associated with it, he/she can avoid transferring stereotypical disclosures and behaviors to a client and provide relevant self-disclosures to the client instead (Barbeau). For example, if a therapist grew up in a family where the mother was a stay-at-home mother, the therapist may treat a female client according to the stereotypical stay-at-home mother. Therefore, therapists need to be mindful of their use of words during a session.

Janusz et al. (2018) have found evidence of "gender discourse" or "gender-related discourse" by a therapist during therapy and its effect on a client's willingness to self-disclose (p. 436). In other words, gender discourse is a way of speaking by a therapist based on his/her values, beliefs, and behaviors manifested within the therapist's gender, and it is connected with a client's willingness to self-disclose. Furthermore, "gender discourse" by the therapist using self-disclosure related to his/her clients' beliefs was associated with an increase in self-disclosures by a couple during a therapy session

(Janusz et al., 2018). For example, when a male therapist expressed self-disclosures of empathy toward a woman who expressed feeling lonely as a stay-at-home wife, she self-disclosed more to her husband during the session. This gender-informed therapist was able to put aside his belief that women should be stay-at-home wives and avoided a biased “gender discourse” during the session. Stokoe (2004) has shown that therapists must use self-disclosures based on the values related to their clients and avoid making self-disclosures based on the gender belief system of the therapist. The work of Muntigl and Horvath (2016) and Diorinou and Tseliou (2014) have echoed the findings of Janusz et al. and Stokoe. Muntigl and Horvath have demonstrated that when a male therapist disclosed that he was nervous, he avoided self-disclosures that were stereotypical of the tough male persona. Consequently, his clients disclosed more during a family session. Therapists must be mindful of their learned gender discourse and avoid self-disclosures that are not in tandem with the belief system of the client.

Summary and Conclusion

This review of the literature described prior research findings concerning therapist self-disclosure, type of therapist self-disclosure, and the gender of a therapist and their relationship to a client’s willingness to self-disclose. The literature review also explored the meaning of therapist self-disclosure, client self-disclosure, and the appropriate use of therapist self-disclosure. This research revealed the limitations of therapist self-disclosure and its possible adverse consequences on clients from no improvement of functioning to dropping out of therapy. Last, two gaps in the literature, the purpose of this study, and ethical issues were identified.

Therapist self-disclosure has been used since the time of Freud (1912/1963) who opposed its use. Over the decades, therapist self-disclosure has been used by many psychologists within their respective fields, both intentionally and unintentionally (Danzer, 2019). It has been studied extensively by many psychologists over the decades (Danzer). Psychologists such as Bitar et al. (2014), Bottrill et al. (2010), and Levitt et al. (2015) have found positive effects on the therapeutic relationship and client willingness to self-disclose.

On the other hand, little of this research had focused on the type of therapist self-disclosure and a client's willingness to self-disclose. This study examined the connection between empathetic and factual forms of therapist self-disclosure and no therapist self-disclosure on a client's willingness to self-disclose. Closing this gap will help psychologists decide when to use empathetic or factual self-disclosure during therapy.

Another area in need of examination is the connection between a therapist's gender and a client's willingness to self-disclose (Danzer; Staczan et al., 2017). Henretty and Levitt (2010) found no significant relationship between a therapist's gender and a client's willingness to self-disclose between 1974 to 2007. Since that time, American society has changed significantly concerning gender issues and rights (Fiske, 2014). Consequently, there is a need to close this gap since we do not know if male or female therapist self-disclosure is related to a client's willingness to self-disclose. Closing this gap will help therapists to be mindful of their gender when working for a client and the client's willingness to self-disclose. If this study demonstrates a strong connection between a therapist's gender and a client's willingness to self-disclose, the therapist may

provide an option for the client. When the client is not willing to self-disclose or feels uncomfortable while self-disclosing, the therapist may ask his/her client if he/she would like a therapist of a different gender. Of course, the therapist would have to ascertain if the lack of client self-disclosure is related to the therapist's gender. Conversely, if this study demonstrates no connection between a therapist's gender and a client's willingness to self-disclose, then the gender of the therapist might not matter in our current culture.

This study is grounded in social learning theory (Bandura, 1976; Olson & Hergenhahn, 2011; Ziv-Beiman et al., 2018). According to Bandura (1986), social learning theory has been used by psychologists in the field of therapy (Cacioppo & Freberg, 2017). The premise here is that psychologists must model appropriate self-disclosures to help clients to self-disclose during a therapeutic session.

Chapter 3 includes a description of the research design, independent and dependent variables, and its connection with the research questions. The target population, how the data will be collected and analyzed, and the statistics used are discussed. A section on ethics, an explanation of the limitations of this study, and its generalizability are provided. Last, procedures for protecting the volunteers' confidentiality are enumerated.

Chapter 3: Research Methodology

Introduction

The central purpose of this quantitative study was to measure a client's willingness to self-disclose when a therapist self-discloses empathetic, factual, or no information (referred to as therapist self-disclosure). A secondary purpose of this study was to determine if there was a connection between a therapist's gender and a client's willingness to self-disclose. I also intended to determine if there were any interactions between the type of therapist self-disclosures mentioned above and the gender of a self-disclosing therapist on a client's willingness to self-disclose.

Current research showed a paucity of evidence concerning the type of therapist self-disclosure and its connection to a client's willingness to self-disclose. According to Lee (2014), there was a need to discover what type of therapist self-disclosure was related to client self-disclosure. Because little research had been done in this area, this study closed the gap concerning the type of therapist self-disclosure and its connection to a client's willingness to self-disclose.

The other area of needed study was the gender of the self-disclosing therapist and whether there was a connection to a client's willingness to self-disclose. I planned to determine if the gender of the therapist had any connection to a client's willingness to self-disclose. If there is a connection, clients should be allowed to gender-match with a therapist (i.e., clients should receive a choice of which gender they want to work with).

Chapter 3 consists of five sections. It begins with a description of the selected quantitative research design and the rationale for its implementation. In the second

section, I explain the process of selecting a sample from the U.S. population. The third section details the procedures for recruitment, participation, data collection, and informed consent. In addition, debriefing procedures for all voluntary participants are given. In the fourth section, I discuss the instrument used to measure the independent variable, which was the Counselor Disclosure Scale (CDS; Hendrick, 1988), and the dependent variable, which was the Emotional Self-Disclosure Scale (ESDS; Snell et al., 2013). Their reliability and validity coefficients will be cited and expounded. In the fifth section, I discuss the data analysis plan with a list of the research questions. Last, threats to validity, limitations of the CDS and ESDS, and ethical procedures will be discussed.

Research Design and Rationale

Using a survey methodology, the quantitative design was used to measure whether a client's willingness to self-disclose was related to the type of therapist self-disclosure and/or the gender of the therapist. In order to implement the quantitative design, the variables must be measurable by a valid and reliable survey (Burkholder et al., 2016; Cooper, 2018; Vogt et al., 2012). The purpose of a quantitative design is to help the researcher quantify and analyze the data via the implementation of a survey (Cohen, 1988; Vogt et al., 2012). One independent variable was the type of therapist self-disclosure (i.e., empathetic, factual, or no therapist self-disclosure). The other independent variable was the gender of the therapist (i.e., male or female). Last, the dependent variable was a client's willingness to self-disclose.

By using quantitative design, a researcher is better able to use statistical evidence to either support or reject research hypotheses (Burkholder et al., 2016). I also wanted to

determine statistically how likely the results were to be generalizable to a larger population (Vogt et al., 2012). Three surveys were sent to those who had been in therapy. They were as follows:

- a demographic questionnaire that I designed,
- the CDS (Hendrick, 1988), and
- the ESDS (Snell et al., 2013).

These surveys are explained in the section called Instrumentation and Operationalization of Constructs. An ANOVA was engaged to help me analyze the within and between connections concerning whether a client's willingness to self-disclose was related to the type of therapist self-disclosure and/or the gender of the therapist. In this study, the research focused on participants' willingness to self-disclose when they had experienced a male or female therapist eliciting factual, empathetic, or no self-disclosures.

Methodology

This section includes the target population that was sampled, sampling procedure, justification for the effect size, alpha level, power level chosen, and tool used to calculate the sample size. Procedures for recruitment, participation, and data collection are discussed. Published instruments for gathering the data are presented with reliability and validity coefficients.

Population

Millions of people in the United States are currently engaging in various types of psychotherapy for a plethora of mental illnesses (Kazdin & Blase, 2011). According to Ehrlich (2020), there has been a significant increase in the number of people attending

therapy because of COVID-19. Ehrlich added that it is mostly anxiety and depression. The target population for this study was adult males and females who were between 18 and 60 years old. According to the National Academies of Sciences, Engineering, and Medicine (2016), people who are over 60 years of age perceive psychotherapy as a stigma and may not be as likely to self-disclose as people who are younger and view psychotherapy more positively. Participants must also have been in therapy for at least three sessions and diagnosed with anxiety and/or depression within the United States. It was believed that participants who had an experience with psychotherapy and therapists who had self-disclosed empathetic, factual, or no self-disclosures would be relevant to the research questions postulated in this study (Levitt et al., 2015). I also wanted to avoid a confounding variable concerning those who had been ordered by the courts to attend sessions because they tend to be more unwilling to participate than those adults who choose to attend psychotherapeutic sessions (Bitar et al., 2014; Burkholder et al., 2016; Danzer, 2019). In addition, the participant must not have had a diagnosis of being psychotic; must not have been addicted to drugs such as heroin, cocaine, or pain killers; must not have been incarcerated or currently pregnant; and must not have had any diagnosed mental disorder that might impair their ability to give consent. Consequently, this population was not surveyed. Last, because millions of people use social media (Taniguchi & Glowacki, 2021), a sample was drawn from this population.

Sampling and Sampling Procedures

A convenience sample (Vogt et al., 2012) was used for this study. The sample consisted of people who lived in the United States. According to the U.S. Census Bureau

(2021), there are 331.8 million people living in the United States. In addition, 65% of the population is between the ages of 15 and 64 (U.S. Census Bureau, 2021), which corresponds approximately to the population I sampled. Because the population has had a plethora of stressors because of Covid-19, there has been an increased need for outpatient psychotherapy (Ehrlich, 2020), which may have helped me obtain an appropriate sample size.

The inclusion criteria for this study were the following:

- was an adult aged between 18 and 60
- had been in therapy for at least three sessions; this requirement was set in order to obtain more relevant data about the research topic (i.e., the research questions concerning a client's willingness to self-disclose during therapy if a male or female therapist self-discloses; Danzer, 2019; Frankfort-Nachmias & Leon-Guerrero, 2015; Vogt et al., 2012).
- had been in therapy for the past 3 to 4 months
- lived in the United States

The exclusion criteria for this study applied to the following:

- participants who were pregnant
- participants who were incarcerated
- participants who were over 60
- participants who had been court-ordered to attend therapy

- participants who had been diagnosed as psychotic; who were addicted to drugs such as heroin, cocaine, or painkillers; or who had any diagnosed mental disorder that might impair their ability to give consent
- participants who did not meet the inclusion criteria stated above and did not complete the survey; these individuals were eliminated from this study to avoid confounding the survey results (Cohen, 1988; Vogt et al., 2012)

The sample size depended on a specific statistical test, the expected alpha level, power level, and effect size (Burkholder et al., 2016; Cohen, 1988; Cooper, 2018; Vogt et al., 2012; Wagner, 2017). The statistical test was a two-way ANOVA to analyze the connections concerning three types of therapist self-disclosure and the gender of the therapist on a client's willingness to self-disclose. The alpha level was set at 95%. This power level reduced the risk of making a Type I error (i.e., rejecting a true hypothesis) to 5% (Frankfort-Nachmias & Leon-Guerrero, 2015). The effect size of the population concerns the relationship between the variables. The larger the effect size, the stronger the relationship will be between the variables (Creswell, 2014).

G*Power was used to compute the minimal sample size based on a medium effect size (Cohen, 1988, 1992; Faul et al., 2007). Also, the number of predictor variables affected the outcome of this power analysis. For this study, the number of predictor variables was two (i.e., therapist self-disclosure and gender of the therapist). The minimum sample size needed for this study using a two-way ANOVA with a power of 80%, medium effect size, and alpha of 95% (Faul et al., 2009; Peng et al., 2017) was

determined to be 158 subjects. These parameters were coterminous with Creswell's (2014) recommendation for quantitative research.

Procedures for Recruitment, Participation, and Data Collection

Approval needed to be obtained from the Walden University Institutional Review Board (IRB). SurveyMonkey was used to recruit a sample of participants and distribute the questionnaires to members of SurveyMonkey's global panel matching the inclusion and exclusion criteria for this study. SurveyMonkey is an online survey service that allows the researcher to add the time needed to take the questionnaires, state the purpose of the study, explain implied consent, give follow-up reminders, and collect data. The informed consent form provided the participants with the purpose, procedures, risks, and benefits of this study (American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, 2014; American Psychological Association, 2010; Creswell, 2014). This form was read by all participants. All surveys sent to participants included a statement that said that all participants would remain anonymous, and the procedures taken to protect the participant's confidentiality would be explained. Participation in this study was voluntary, and those who volunteered could terminate the surveys at any time.

Three questionnaires were administered to SurveyMonkey's global panelists. SurveyMonkey sent the surveys to those who had been in therapy for the past several years. Participation in this study consisted of completing the questionnaires. No participant names were collected. I provided my contact information in case the participants had any questions before and after taking the survey. SurveyMonkey was

hired to send the surveys, collect the data, and export the data into a statistical software program called SPSS.

Instrumentation and Operationalization of Constructs

Three questionnaires were used in this study. The first questionnaire asked for demographic information (see Appendix A). The second questionnaire was the CDS (Hendrick, 1988; see Appendix B), which measured the type of therapist self-disclosure or no self-disclosure. The third questionnaire was the ESDS (Snell et al., 2013; see Appendix C), which measured the willingness of the respondents to self-disclose to their therapist.

Demographic Questionnaire

The demographic questionnaire (see Appendix A) consisted of six questions with multiple-choice answers. It was designed by me. It took approximately 2 minutes to complete. The following items comprised the demographic questionnaire:

1. What is your gender?
    a. Male
    b. Female
    c. Non-binary
2. What is the gender of your therapist?
    a. Male
    b. Female
    c. Non-binary
3. What is your age?

a. 18 to 24

b. 25 to 34

c. 35 to 44

d. 45 to 54

e. 55 to 60

4. What is your annual income?

a. $25,000 to $35,000

b. $36,000 to $45,000

c. $46,000 to $55,000

d. $56,000 to $65,000

e. $66,000 to $75,000

f. Over $75,000

5. What is your race?

a. Caucasian

b. Black

c. Hispanic

d. Asian

e. Multiracial

Counselor Disclosure Scale (CDS)

The CDS (see Appendix B) was developed by Hendrick (1988) to measure a therapist's type of self-disclosure. The CDS is a 38-item survey to examine six types of counselor self-disclosures that takes about 10 minutes to complete (Hendrick, 1988).

Questions on each of the subscales were measured using a Likert scale ranging from 1 (*strongly agree*) to 5 (*strongly disagree*). Hendrick's goal was to "(a) ask potential clients (in this case undergraduate students) what kinds of self-disclosures might be desirable from a counselor, (b) to develop and refine a counselor self-disclosure scale" (p. 419). The six subscales are (a) Interpersonal Relationships, (b) Personal Feelings, (c) Sexual Issues, (d) Professional Issues, (e) Success/Failure, and (f) Attitudes.

The Interpersonal subscale measures the counselor's relationship with their spouse, children, parents, and close friends. The Personal Feelings subscale measures the counselor's feelings of anxiety, depression, happiness, anger, and physical appearance. The Sexual Issues subscale measures the counselor's attitudes toward sex, personal sexual practices, orientation, and whether they have been sexually abused. The Professional Issues subscale measures the counselor's professional degree, training and professional experience, theoretical approach to counseling, and the diagnosis they have given the client. The Success/Failure subscale measures the counselor's personal successes and failures and their professional successes and failures. Last, the Attitudes subscale measures the counselor's religious beliefs, political views, and health.

To develop this scale, Hendrick (1990) wanted to compare client responses on the CDS with responses from undergraduate research participants at Texas Technical University who volunteered for this study. A sample of 24 (i.e., 12 male and 12 female) participants was randomly drawn from this undergraduate population (N = 104) (Hendrick, 1990, p. 185). The two samples were referred to as the Client sample and Undergraduate sample. Consequently, a two-by-two ANOVA was used to compare the

gender (male/female) and sample type (Client/Undergraduate) with the scores on the six subscales of the CDS. The subscales served as the dependent variables. She found no significant correlations between the gender of the therapist and a client's willingness to self-disclose on five of the six subscales, with the exception being the Sexual Issues subscale [F (1,44) = 8.16, $p < .05$] (p. 185). Concerning the Sexual Issues subscale, men were more willing to talk about sexual issues with male therapists who self-disclosed sexual issues than female therapists who did. Using an ANOVA, she discovered that five out of 38 items were related to differences in the therapist's gender. In addition, there was a strong positive correlation between the therapist's Personal Feelings subscale (i.e., r = .69 and $p < .05$) and a client's willingness to self-disclose (Hendrick, 1988, p. 420). A therapist's personal feelings included items related to their emotions of happiness or anger. In other words, the more that the therapist self-disclosed personal feelings, the more information clients self-disclosed about themselves. Another significant finding was on the Success/Failure subscale [F (1,44) = 6.71, $p < .05$] (Hendrick, 1990, p. 185). Participants who were undergraduates desired more self-disclosure about a counselor's successes and failures than did the Client participant group. Last, results on the counselor's Professional Issues subscale were strongly and positively correlated with a client's willingness to self-disclose (i.e., factual disclosures were r = .84 and $p < .05$; Hendrick, yea p. 421). Items on the Professional Issues subscale included their degree, training/professional experiences, theoretical approach to counseling, diagnosis given to the client, and whether the therapist liked their work. Internal reliability on the subscales ranged from r = .86 on both Personal Feelings and Interpersonal Relationships to r = .71

for Attitudes (Hendrick, 1990, p. 422). Results from a second study using the CDS indicated acceptable internal consistency "with alphas ranging from .71 to .86" (Hendrick, 1990, p. 423). Last, Dr. Hendrick has given me permission to use her scale via email (see Appendix D).

Emotional Self-Disclosure Scale (ESDS)

The ESDS (Snell et al., 1988) (see Appendix C) was developed to assess how willing people are to discuss specific emotions with different disclosure recipients and takes about 15 minutes to complete. It is comprised of 40 items measuring eight subscales, each with five separate items. The subscales are: (1) Depression, (2) Happiness, (3) Jealousy, (4) Anxiety, (5) Anger, (6) Calmness, (7) Apathy, and (8) Fear. The *Depression* subscale measures the respondent's level of sadness. The Happiness subscale measures the respondent's level of cheerfulness. The Jealousy subscale measures the respondent's level of envy. The Anxiety subscale measures the respondent's level of worry. The Anger subscale measures the respondent's level of displeasure. The Calmness subscale measures the respondent's level of tranquility. The Apathy subscale measures the respondent's level of indifference. Last, the Fear subscale measures the respondent's level of alarm (Snell et al.). This questionnaire provides a five-point Likert scale which is interval-based from 0 to 4 (Warner, 2013) concerning the amount of self-disclosure a participant is willing to discuss within each subscale with the therapist he/she has experienced (Snell et al.). The highest score a participant can achieve is a 20 for each of the subscales. The self-disclosure 5-point Likert rating scale was as follows:

0: I have not discussed this topic with my counselor.

1: I have slightly discussed this topic with my counselor.

2: I have moderately discussed this topic with my counselor.

3: I have almost fully discussed this topic with my counselor.

4: I have fully discussed this topic with my counselor (Snell et al., p. 3).

The ESDS has been used to investigate the willingness of people to self-disclose to others (Snell et al., 1989). Seventy-nine undergraduate students volunteered for this study. There were 36 males, 37 females, and 6 participants who did not identify their gender. Two types of reliability analyses were conducted on the eight subscales on the ESDS (i.e., Cronbach's alpha and test-retest). The internal reliability ranged from $r = .83$ to $r = .95$ among the eight subscales (Snell et al., 1988, p. 63). Consequently, there was evidence that the items for each of the eight subscales were clear and internally consistent for each of the three types of disclosure participants (i.e., *female friends*, *male friends*, and *spouses/lovers*) (Snell et al., p. 59). In addition, reliability was also assessed through a test-retest correlation. Pearson's r (i.e., test-retest) (Warner, 2013) ranged from $r = .35$ to $r = .72$ (Snell et al., p. 64). In other words, there was consistent evidence of stability concerning these scores over time. Another set of analyses was conducted to examine the intercorrelations between the subscales on the ESDS. These intercorrelations between the eight subscales were higher for *female friends* disclosure, ($r = .78$, $p < .001$) than for *spouses/lovers* disclosure (r = .70) or for *male friends* disclosure ($r = .65$, $p < .001$) (p. 64). These findings indicate that the participants' willingness to disclose any one emotion with their female friends was strongly connected with a willingness to discuss other types of emotions listed in the scale with the same friends. In addition, the MANOVA main

effect for gender associated with the participants' willingness to discuss their emotions with their *male friends* was significant statistically [F (8,64) = 3.08, p < .05]. In other words, both males and females were willing to discuss their feelings with their *male friends*. Concerning the emotional disclosure to *female friends*, females and males did differ in their willingness to discuss their emotions with a *female friend* [F (8,64) = 2.60, p < .016]. On five of the ESDS subscales, women were more willing to discuss their emotions of depression, jealousy, anxiety, anger, and fear with their *female friends* than males. Last, the third MANOVA concerned the participants' willingness to discuss their emotions with their *spouses/lovers*. It was statistically significant [F (8,64 = 4.24. p < .001] on four of the eight subscales of d*epression*, *anxiety*, *ange*r, and *fear*. Men were less willing to discuss their feelings than women were. Last, use of the scale was granted by the publisher (see Appendix E).

Data Analysis Plan

This study examined two different relationships and their interaction effects according to the three research questions stated earlier. The three research questions and hypotheses studied are as follows:

RQ1—Quantitative: Is client willingness to self-disclose related to the type of therapist self-disclosure?

H_0: There is no difference in client willingness to self-disclose based on therapist empathetic, factual, or no therapist self-disclosure.

H_1: There is a difference in client willingness to self-disclose based on therapist empathetic, factual, or no therapist self-disclosure.

RQ2—Quantitative: Is client willingness to self-disclose related to the gender of therapist self-disclosure?

H_0: There is no difference in client willingness to self-disclose based on the gender of therapist self-disclosure.

H_1: There is a difference in client willingness to self-disclose based on the gender of therapist self-disclosure.

RQ3—Quantitative: Is client willingness to self-disclose related to the interaction effect between empathetic, factual, or no therapist self-disclosures and the therapist's gender?

H_0: There is no interaction effect in client willingness to self-disclose between empathetic, factual, or no therapist self-disclosures and the therapist's gender.

H_1: There is an interaction effect in client willingness to self-disclose between empathetic, factual, or no therapist self-disclosures and the therapist's gender.

Because of the specific nature of the independent variables (i.e., categorical for therapist self-disclosure with three levels, and categorical for the gender of the therapist with two levels, as well as the dependent variable which will be continuous from 0 to 4 on a Likert scale), the statistic that was used to analyze the data was a two-way ANOVA (Frankfort-Nachmias & Leon-Guerrero, 2015; Laureate Education, 2017; Liu, 2021; Warner, 2013). Last, the data collected was exported to a statistical software program called the Statistical Package for the Social Sciences (SPSS) (Wagner, 2017) for analysis.

Preliminary Data Analysis

For each of the surveys, *Survey Monkey* removed any surveys that were not completed correctly. Any participant who skipped a survey was eliminated. Last, participants who skipped any questions within each survey were also eliminated from the data set.

There were several assumptions when using a two-way ANOVA concerning the three hypotheses listed above. The assumptions were that the sample was drawn from a normally distributed population, the observations in each group were independent of each other, and the variances of the populations were equal (Creswell, 2014; Frankfort-Nachmias, & Leon-Guerrero, 2015). In other words, the variation around the mean for each group being compared were similar among all groups. To assess normality, box plots, histograms, and Q-Q plots were used. Because each participant was measured once, independence can be assumed. To test for equal variance, the Levene's test was conducted (Creswell). If the data did not meet these assumptions, a non-parametric alterative such as the Kruskal-Wallis test would be implemented (Creswell). All categorical independent variables are displayed using frequencies, while continuous variables are displayed using means, standard deviations, and F-Ratios for the three groups.

Threats to Validity

This section will examine threats to internal and external validity, as well as ethical procedures. All studies have threats to validity which can reduce the generalizability of the results (Roberts, 2010). Since all studies have limitations, it is

paramount that the researcher identifies these limitations to the reader and states what cannot be controlled and what can be designed to minimize these threats (Creswell, 2014). Last, ethical procedures are needed to increase trust with the researcher so that the participants are more open with their responses to the survey questions.

Threats to Internal Validity

Internal validity relates to how well the study was constructed, the accuracy of instrumentation, and population selection (Roberts, 2010). Several types of internal validity include face, content, and construct validity, and each can pose a threat to internal validity. Face validity of a survey is the extent to which it appears to be relevant, important, and interesting to the examinee (Groth-Marnat, 2009). To reduce this threat, the surveys used in this study were copied exactly as the creators had made them. Content validity occurs when the items in the survey correspond to the behavior and subject matter identified in the study (Groth-Marnat). Both instruments were carefully examined to measure therapist self-disclosure by the Counselor Disclosure Scale (Hendricks, 1988) and client willingness to self-disclose as measured by the Emotional Self-Disclosure Scale (Snell et al., 2013). Possible threats to their validity included how the participants interpreted the type of therapist self-disclosure on the former scale and the outcome variables on the latter scale. Construct validity concerns whether the survey measures what it is supposed to measure (Groth-Marnat). In this case, it is the type of therapist self-disclosure and a client's willingness to disclose concerning certain variables on the Emotional Self-Disclosure Scale. One limitation may include the participant's interpretation of the words on these surveys.

Another possible threat to internal validity was selection bias. Participants were randomly selected via *Survey Monkey*; however, the researcher cannot tell how many participants were motivated or have had enough time from their lives to have taken these surveys. Also, it was possible participants could have lied about the inclusion criteria such as their age, gender, how long they have been in therapy, and if they live in the United States. The use of a demographic survey was used to track for any inclusion and exclusion criteria that may have been over- or under-presented.

Several other threats to internal validity included attrition, maturation, and historical effects. Attrition occurs when participants drop out of a study. One way to reduce this threat was to implement short surveys (Creswell, 2014; Roberts, 2010). When participants change over time, maturation occurs (i.e., participants can become bored or change their views over time). Also, since there was a large age range concerning the participants, views on issues could have varied due to time, place, and the culture of the participants (Fiske, 2014). Last, historical effects concern events that occur outside of the study that affects participants' decision-making processes (Creswell). Maturation and historical effects were minimized by giving the surveys once (Roberts; Wright, 2005).

Another threat to internal validity concerned the validity and reliability of the instruments that were used in this study (Creswell, 2014). If the instruments had not been tested over time, then their validity and reliability would have affected the internal results of this study. To avoid this problem, instruments were chosen based on good psychometric properties.

Threats to External Validity

Threats to external validity include variables that pose a threat to the generalizability of the results. External validity occurs when the researcher "draws incorrect inferences from the sample data to other persons, other settings, and past and future situations" (Creswell, 2014, p. 176). These threats include selection bias, situational factors, and historical effects (Creswell, 2014). Because of the narrow inclusion criteria of the participants, the researcher cannot generalize the results to those who do not have these characteristics. To minimize this threat, the research must mention that generalizability is only acceptable to those with similar characteristics or retest with other groups (Creswell). Situational factors such as the online distribution of the surveys via *Survey Monkey* may not be generalizable to populations that do not use the internet. According to Creswell (2014), the researcher cannot generalize the results to past or future situations. Similarly, the researcher must be able to replicate the results at a later time.

Ethical Procedures

This study was reliant on the Institutional Review Board's (IRB's) approval at Walden University. The sample population was protected by the ethical codes in the *American Psychological Association Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association., 2010) and the Walden IRB ethical guidelines. This study incorporated a non-vulnerable population that did not violate ethical procedures posted at Walden University. Also, no participants worked for the researcher or were known by the researcher. Participants were over 18 years of age, have

signed a consent form, and told they can discontinue at any time without a penalty. The consent form (see Appendix F) was given to all participants in the form of an electronic download. The form included the purpose of the study, confidentiality limitations, and the procedures that needed to be followed. The consent form included an identification number. The collected data were stored and secured in a password-protected file on a flash drive for five years according to Walden IRB ethical guidelines. In addition, all participants have access to the results of the study and the researcher's contact information via an electronic link at Walden University.

Summary

The main purpose of this study was to determine if therapist self-disclosures were related to a client's willingness to self-disclose. Another purpose was to discover whether the gender of the therapist was related to a client's willingness to self-disclose. The last research question concerns whether there were any interaction effects between a therapist's self-disclosure and gender on a client's willingness to self-disclose.

This chapter explained the methodology, research design, sample population, instrumentation, procedures for data collection, and statistical procedures used. Using a survey methodology, a quantitative design was used to measure therapist self-disclosure on two surveys (CDS and ESDS). A two-way ANOVA was conducted to assess the relationships between the type of therapist self-disclosure and gender of the therapist on a client's willingness to self-disclose. *Survey Monkey* was employed to advertise and distribute the surveys, and an informed consent form was included after obtaining IRB

approval. Last, attention had been discussed concerning ethics, the rights of the participants, and confidentiality protections.

Chapter 4 will present the process of data collection, the time frame for data collection, and response rates. Any miscalculations or errors will be addressed concerning attrition, maturation, and historical effects. Each research question will be addressed using a two-way ANOVA. Also, alpha levels, effect size, G*Power, and F outcomes will be discussed and presented in the form of tables, graphs, and figures.

Chapter 4: Results

Introduction

The purpose of this study was to determine if there is a connection between a therapist's engagement in empathetic, factual, or no self-disclosure and a client's willingness to self-disclose during therapy sessions. A secondary purpose of this study was to determine if there was a connection between a therapist's gender and a client's willingness to self-disclose. The third purpose was to determine if there were any interactions between the type of therapist self-disclosures mentioned above and the gender of a self-disclosing therapist on a client's willingness to self-disclose. The first research question focused on whether a client's willingness to self-disclose was related to the type of therapist self-disclosure. The second research question focused on whether a client's willingness to self-disclose was related to the gender of the therapist engaging in self-disclosure. Last, the third research question focused on whether there were any interaction effects of a therapist's empathetic, factual, or no self-disclosures and the therapist's gender on a client's willingness to self-disclose during therapy.

This chapter is divided into three sections addressing data collection, results, and a chapter summary. The data collection section contains a brief description of the participants, any possible weaknesses related to the data collection process, relevant statistics, and why some covariates were eliminated. All statistics implemented are explained, along with their purpose and a statistical analysis of the results collected. A final section is included to provide a summary for each research question.

Data Collection

Time Frame and Response Rates

The data were collected via SurveyMonkey and took 1 week. Two-hundred forty-two people returned the survey**.** Of the 242 respondents, 198 (82%) people completed all of the CDS and ESDS surveys within the continental United States. Thus, 44 responses were discarded from the analysis. Tables 1 through 6 compare the demographic information of the total respondents with the resulting sample to assess differences in the distribution.

Descriptive Statistics

The summaries of the geographic residence regions of the respondents and sample are provided in Table 1. The continental regions in the United States included East North Central, East South Central, Middle Atlantic, Mountain, New England, Pacific, South Atlantic, West North Central, and West South Central. The majority of participants resided in East North Central region (19%). The second most numerous regions were Middle Atlantic (12.8%), Pacific (16.9%), South Atlantic (13.6%), and West South Central (10.3%). A similar distribution is seen in the sample. The majority of the sample resided in the East North Central region (19.2%). The second most numerous regions were the Pacific (15.2%), South Atlantic (15.7%), and Middle Atlantic (12.1%).

Table 1

Geographical Regions of Residence Within the Continental United States

Region	Total respondents [a] *N* (%)	Sample [b] *N* (%)
East North Central	46 (19.0)	38 (19.2)
East South Central	16 (6.6)	11 (5.6)
Middle Atlantic	31(12.8)	24 (12.1)
Mountain	17 (7.0)	13 (6.6)
New England	8 (3.3)	8 (4.0)
Pacific	41 (16.9)	30 (15.2)
South Atlantic	33 (13.6)	31 (15.7)
West North Central	13 (5.4)	11 (5.6)
West South Central	25 (10.3)	23 (11.6)

[a] Twelve (5%) of the total respondents did not respond. [b] Nine (4.5%) of the sample did not respond.

A chi-square test was conducted to compare the region distribution to assess if there was a difference between the total respondents and the sample. Overall, there was no statistically significant difference between the regional distribution of the total respondents and the sample size ($\chi^2(8) = 1.13$, $p = .997$). Please note that 5% of the total respondents and 4.5% of the sample respondents did not respond regarding geographic residence as is shown in Table 1.

The distribution of respondent gender is presented in Table 2. Out of the 242 participants, the majority were female (54.4%), 47.5% were male, and 1.7% identified as nonbinary. The female-to-male ratio is 1 - .06. One person responded “other.” When asked to specify, the participant responded “unsure.” Of the sample, the majority were female (54%), 44% were male, and 1% identified as nonbinary. A chi-square test was conducted to compare the gender distribution to assess if there was a difference between

the total respondents and the sample. There was no statistically significant difference in the distribution of the participant's gender ($\chi^2(3) = 0.85$, $p = .84$).

Table 2

Summary of Gender

Gender of participant	Total respondents *N* (%)	Sample *N* (%)
Female	122 (54.4)	107 (54)
Male	115 (47.5)	88 (44.4)
Nonbinary	4 (1.7)	2 (1.0)
Other	1 (0.4)	1 (0.5)

The gender of the participants' therapist is presented in Table 3. The majority of the therapists were female therapists (63.2), and 31% were male therapists. Nonbinary and other categories comprised 5.7%. It is not known what the category *Other* refers to. The majority of female participants (67.3%) attended a female therapist, while most of the male participants (84%) attended a male therapist. Last, the nonbinary participant attended a nonbinary therapist.

A chi-square was conducted to compare the distribution of the therapist's gender to assess if there was a difference between the total respondents and the sample. There was no statistically significant difference in the distribution of therapist gender ($\chi^2(3) = 1.24$, $p = .74$).

Table 3

Distribution of Therapist's Gender

Gender of therapist	Total respondents *N* (%)	Sample *N* (%)
Gender		
Female	153 (63.2)	133 (67.2)
Male	75 (31)	56 (28.3)
Nonbinary	3 (1.2)	1 (0.5)
Other	11 (4.5)	8 (4.0)

Table 4 provides the age range of the participants. The majority of the respondents were between 25 and 34 years old (27.7%) and 35 and 44 years old (26%). It is possible that they had better insurance coverage or did not feel that therapy is a stigma, as older participants might have.

Table 4

Distribution of Age

Age range	Total respondents *N* (%)	Sample *N* (%)
Age (years)		
18–24	42 (17.4)	35 (17.7)
25–34	67 (27.7)	58 (29.3)
35–44	63 (26)	50 (25.3)
45–54	49 (20.2)	38 (19.2)
55–60	21 (8.7)	17 (8.6)

The annual income of the respondents is presented in Table 5. Most of the participants had an annual income less than $45,000 (54.1%). Only a few (7.9%) had an annual income over $75,000. A chi-square was conducted to compare the distribution of annual income age to assess if there was a difference between the total respondents and

the sample. There was no statistically significant difference in the distribution of annual income between the total respondents and the sample ($\chi^2(4) = .73$, $p = .98$).

Table 5

Summary of Annual Income

Annual income range	Total respondents *N* (%)	Sample *N* (%)
Between $25,000 and $35,000	79 (32.6)	66 (33.3)
Between $36,000 and $45,000	52 (21.5)	37 (18.7)
Between $46,000 and $55,000	40 (16.5)	35 (17.7)
Between $56,000 and $65,000	32 (13.2)	28 (14.1)
Between $66,000 and $75,000	20 (8.3)	15 (7.6)
Over $75,000	19 (7.9)	17 (8.6)

The last factor from the demographic survey provides the distribution of race (see Table 6). The majority of the respondents identified as Caucasian (60.3%). Asian and Hispanic were 12% and 16.5%, respectively, while Black American and multiracial were 8.3% and 2.9%, respectively. A chi-square was conducted to compare the distribution of race to assess if there was a difference between the total respondents and the sample. There was no statistically significant difference in the distribution of annual age between the total respondents and the sample ($\chi^2(5) = .82$, $p = .94$).

Table 6

Distribution of Race

Race	Total respondents *N* (%)	Sample *N* (%)
Asian	29 (12)	19 (9.6)
Black/African-American	20 (8.3)	18 (9.1)
Caucasian	146 (60.3)	120 (60.6)
Hispanic	40 (16.5)	34 (17.2)
Multiracial	7 (2.9)	7 (3.5)

To ensure that the participants were a random subset of the total respondents, chi-square tests were conducted on the distributions presented in Tables 1–6. As noted in each table, there were no statistically significant differences in the distributions ($p > .05$), suggesting that there were no systematic differences in the respondents and the subsequent sample.

Results

This section contains a tabulated summary of the data collected via SurveyMonkey. The data address each of the three research questions. The independent variable was the type of therapist self-disclosure (i.e., factual, empathetic, or no self-disclosure). The second independent variable was the therapist's gender (i.e., male or female). Both independent variables were measured by implementing the CDS. The CDS had a Cronbach's alpha of .94, which is strong, according to Creswell (2014) and Vogt et al. (2012). The dependent variable was the client's willingness to self-disclose during a therapy session. Client willingness to self-disclose was measured by the ESDS. The Cronbach's alpha was also high at .97 (Creswell, 2014; Vogt et al., 2012).

Preliminary Analysis

Prior to analyzing the data, Cronbach's alpha was calculated to assess the reliability of each scale and subscale. The reliability analysis is presented in Table 7. For the CDS, Cronbach's alpha ranged from .70 for Attitudes to .86 for Personal. The Cronbach's alpha for the entire scale was .94, suggesting sufficient reliability for the CDS.

Table 7

Reliability Analysis

Scale	Cronbach's alpha
CDS total scale	.94
Interpersonal Relations	.84
Personal	.86
Sexual	.85
Professional	.79
Success/Failure	.85
Attitudes	.70
ESDS total scale	.97
Depression	.82
Happiness	.89
Jealousy	.86
Anxiety	.84
Anger	.84
Calmness	.84
Apathy	.85
Fear	.87

The ESDS was also assessed for sufficient reliability. The total scale had a Cronbach's alpha of .97. The Cronbach's alpha ranged from .82 for Depression to .89 for Happiness. The Cronbach's alpha indicated that there was sufficient reliability for the ESDS.

Descriptive Statistics

The CDS consisted of six scales. The averages of the respondents are provided in Table 8. The scale averages ranged from 9.48 (*SD* = 2.85) for Attitudes to 21.63 (*SD* = 5.02) for Personal. The scales were categorized into Empathetic and Factual based on the questions asked in each scale. The Empathetic scales were Interpersonal and Personal. The Factual scales were Sexual, Professional, Success, and Attitude. To further classify each respondent as being Empathetic and Factual, the average score of each scale was computed. A score of 2.5 and greater was classified as being either Empathetic or Factual for each scale. With a score of less than 2.5, the respondent was classified as not being Empathetic or Factual for each scale.

Table 8

Summary of the Counselor Disclosure Scale Scales Means

Scale	Mean (*SD*)
Interpersonal	15.80 (4.16)
Personal	21.63 (5.02)
Sexual	10.66 (4.10)
Professional	14.84 (3.13)
Success	11.02 (2.97)
Attitudes	9.48 (2.85)

The summary of the presence or absence of being Empathetic or Factual counselors for each scale is presented in Table 9. The majority of respondents classified their counselor as Empathetic on both scales. One hundred ten respondents (56%) were classified as being Empathetic on the Interpersonal scale and 120 (61%) on the Personal scale. The majority of respondents were classified as having Factual counselors on the Professional (*n* = 157 (79%) and Success scales (*n* = 118 (60%)). The Sexual and

Attitude scales had fewer than 40% of the respondents reporting their counselors as Factual.

Table 9

Summary of the Counselor Disclosure Scale Scales Empathetic or Factual

Scale	Yes *N* (%)	No *N* (%)
Empathetic		
Interpersonal	110 (55.6)	88 (44.4)
Personal	120 (60.6)	78 (39.4)
Factual		
Sexual	57 (28.8)	141 (71.2)
Professional	157 (79.3)	41 (20.7)
Success	118 (59.6)	80 (40.4)
Attitude	71 (35.9)	127 (64.1)

The summary statistics of the ESDS are presented in Table 10. The ESDS scale scores range from 5 to 25. On average, respondents rated Depression highest (M = 16.85, SD = 4.68) and Jealousy lowest (M = 13.75, SD = 5.36).

Table 10

Summary of the Emotional Self-Disclosure Scale Scales

Scale	Mean (*SD*)
Depression	16.85 (4.68)
Happiness	15.32 (5.29)
Jealousy	13.75 (5.36)
Anxiety	16.74 (4.63)
Anger	15.42 (5.02)
Calmness	14.46 (5.01)
Apathy	14.56 (5.21)
Fear	15.41 (5.09)

Research Question 1

RQ1—Quantitative: Is client willingness to self-disclose related to the type of therapist self-disclosure?

H_0: There is no difference in client willingness to self-disclose based on therapist empathetic, factual, or no therapist self-disclosure.

H_1: There is a difference in client willingness to self-disclose based on therapist empathetic, factual, or no therapist self-disclosure.

To examine the client's willingness to self-disclose based on the therapist's self-disclosure, the average CDS scales were compared to the presence of Empathetic and Factual counselor self-disclosure. Tables 11 to 18 presents the comparison of each ESDS scale with the therapist's self-disclosure based on the CDS.

The participant's willingness to disclose depression based on the counselor's self-disclosure is presented in Table 11. Counselors self-disclosing Factual Success has a statistically significant difference on Depression. On average, participants Depression score is significantly higher ($t(196) = 3.48$, $p < .001$) when counselors self-disclose Success. There is an average difference 2.29 in the scale score. There were no other statistical differences ($p > .05$) in the Depression scale.

Table 11

Depression

CDS	Yes Mean (*SD*)	No Mean (*SD*)	*t* test	*p*-value
Empathetic				
Interpersonal	17.23 (4.73)	16.40 (4.60)	1.23	.22
Personal	17.08 (4.72)	16.51 (4.62)	.83	.41
Factual				
Sexual	17.12 (4.59)	16.74 (4.73)	.51	.61
Professional	16.88 (4.75)	16.76 (4.44)	.15	.88
Success	17.78 (4.46)	15.49 (4.69)	3.48	< .001***
Attitude	16.94 (4.97)	16.80 (4.53)	.20	.84

*** denotes statistical significance at the .001 level of significance.

The Happiness Scale is provided in Table 12. There were statistically significant differences in Empathetic Personal scale ($t(196) = 2.48$, $p = .007$) and the Factual Sexual ($t(196) = 1.99$, $p = .05$), and Success scales ($t(196) = 2.78$, $p = .006$). On average, participants disclosed happiness more when the counselor self-disclosed Personal information (*M* = 16.97, *SD* = (5.05) *vs.* *M* =14.18, *SD* = (5.49)). With respect to Factual information, on average participants had higher scores on the Happiness scale when the counselor self-disclosed Sexual (*M* = 16.49, *SD* = (4.72) vs. *M* = 14.85, *SD* = (5.45)) and Success (*M* =16.17, *SD* = (5.01) *vs.* *M* = 14.08, *SD* = (5.48)). No other type of counselor self-disclosure had a significant difference in the Happiness Scale.

Table 12

Happiness Scale

CDS	Yes Mean (*SD*)	No Mean (*SD*)	*t* test	*p*-value
Empathetic				
Interpersonal	15.97 (4.95)	14.51 (5.62)	1.94	.06
Personal	16.97 (5.05)	14.18 (5.49)	2.48	.007**
Factual				
Sexual	16.49 (4.72)	14.85 (5.45)	1.99	.05*
Professional	15.36 (5.24)	15.17 (5.53)	.21	.84
Success	16.17 (5.01)	14.08 (5.48)	2.78	.006**
Attitude	16.18 (5.05)	14.84 (5.39)	1.72	.09

* denotes statistical significance at the .05 level of significance. ** denotes statistical significance at the .01 level of significance.

The comparison of the Jealousy scale is provided in Table 13. With the exception of Factual Professional counselor disclosure, all counselor disclosures were statistically significant ($p < .05$). On average, when the counselor disclosed interpersonal, personal, sexual, success and attitude information, participants scored higher on the Jealousy scale.

Table 13

Jealousy Scale

CDS	Yes Mean (*SD*)	No Mean (*SD*)	*t* test	*p*-value
Empathetic				
Interpersonal	14.42 (5.22)	12.91 (5.45)	1.98	.049*
Personal	14.38 (5.19)	12.77 (5.51)	2.09	.02*
Factual				
Sexual	15.65 (5.13)	12.98 (5.27)	3.25	.001***
Professional	13.48 (5.53)	14.78 (5.53)	-1.39	.18
Success	14.68 (5.31)	12.38 (5.17)	3.03	.003**
Attitude	15.42 (5.21)	12.81 (5.23)	3.73	< .001***

* denotes statistical significance at the .05 level of significance. ** denotes statistical significance at the .01 level of significance. *** denotes statistical significance at the .001 level of significance.

The comparison of the Anxiety scale is provided in Table 14. The counselor disclosure of Success was statistically significantly different ($t(196) = 3.25$, $p = .001$) on the participant's anxiety score. On average, the anxiety score was higher ($M = 17.60$, $SD = 4.43$) when the therapist disclosed Success than when they did not ($M = 15.48$, $SD = 4.66$). There were no other types of counselor disclosures that were statistically significant ($p > .05$).

Table 14

Anxiety Scale

CDS	Yes Mean (*SD*)	No Mean (*SD*)	*t* test	*p*-value
Empathetic				
Interpersonal	17.01 (4.79)	16.41 (4.42)	.90	.37
Personal	17.05 (4.73)	16.27 (4.45)	1.61	.12
Factual				
Sexual	17.04 (4.56)	16.62 (4.67)	.57	.57
Professional	16.74 (4.62)	16.73 (4.72)	.02	.99
Success	17.60 (4.43)	15.48 (4.66)	3.25	.001
Attitude	16.59 (4.83)	16.83 (4.53)	-.34	.73

*** denotes statistical significance at the .001 level of significance.

The comparison of Anger scale is provided in Table 15. The counselor disclosure of Success was statistically significant ($t(196) = 2.67$, $p = .008$) on the participant's Anger scale. On average, the anger score was higher ($M = 16.19$, $SD = 4.73$) when the therapist disclosed Success than when they did not ($M = 14.29$, $SD = 5.24$). There were no other type of counselor disclosures that were statistically significant ($p > .05$).

Table 15

Anger Scale

CDS	Yes Mean (*SD*)	No Mean (*SD*)	*t* test	*p*-value
Empathetic				
Interpersonal	16.15 (4.98)	14.51 (4.93)	2.32	.02*
Personal	16.08 (4.84)	14.42 (5.14)	2.29	.01*
Factual				
Sexual	16.25 (4.83)	15.09 (5.07)	1.47	.14
Professional	15.29 (4.92)	15.93 (5.40)	-.72	.47
Success	16.19 (4.73)	14.29 (5.24)	2.67	.008
Attitude	16.37 (4.73)	14.90 (5.11)	1.99	.05*

* denotes statistical significance at the .05 level of significance. ** denotes statistical significance at the .01 level of significance.

The comparison of Calmness scale is provided in Table 16. The counselor disclosure of Success was statistically significant ($t(196) = 2.79$, $p = .006$) on the participant's Anger scale. On average, the anger score was higher (M =15.26, SD = 4.79) when the therapist disclosed Success than when they did not (M = 13.28, SD = 5.12). There were no other types of counselor disclosures that were statistically significant ($p >$ .05).

Table 16

Calmness Scale

CDS	Yes Mean (*SD*)	No Mean (*SD*)	*t* test	*p*-value
Empathetic				
Interpersonal	13.82 (4.68)	14.01 (5.38)	1.13	.26
Personal	14.85 (4.81)	13.86 (5.27)	1.36	.09
Factual				
Sexual	15.63 (4.58)	13.99 (5.11)	2.11	.04*
Professional	14.45 (4.90)	14.49 (5.46)	-.04	.97
Success	15.26 (4.79)	13.28 (5.12)	2.79	.006**
Attitude	15.10 (4.96)	14.10 (5.02)	1.35	.18

* denotes statistical significance at the .05 level of significance. ** denotes statistical significance at the .01 level of significance.

The comparison of the Apathy scale is presented in Table 17. With the exception of Personal and Professional scales, all scales were statistically significant ($p < .05$). On average, participants score higher on Apathy when the counselor disclosed Interpersonal (MD = 1.48), Sexual (MD = 2.1), Success (MD = 2.13), and Attitude (MD = 1.55) information.

Table 17

Apathy Scale

CDS	Yes Mean (*SD*)	No Mean (*SD*)	*t* test	*p*-value
Empathetic				
Interpersonal	15.21 (4.86)	13.73 (5.54)	2.02	.045*
Personal	15.09 (5.05)	13.73 (5.38)	1.34	.09
Factual				
Sexual	16.05 (4.56)	13.95 (5.35)	2.61	.01*
Professional	14.32 (5.10)	15.44 (5.60)	-1.22	.22
Success	15.42 (5.06)	13.29 (5.20)	2.87	.005**
Attitude	15.55 (4.92)	14.00 (5.31)	2.02	.05*

* denotes statistical significance at the .05 level of significance. ** denotes statistical significance at the .01 level of significance.

The comparison of the Fear scale is presented in Table 18. There were statistically significant differences with the Personal ($t(196) = 2.17$, $p = .02$), Sexual ($t(196) = 2.38$, $p = .02$) and Success ($t(196) = 1.62$, $p = .01$). On average, participants scored higher on the Fear scale when the counselor disclosed Personal ($M = 16.04$ vs. $M = 14.45$), Sexual ($M = 16.75$ *vs.* $M = 14.87$) and Success ($M = 16.17$ *vs.* $M = 14.30$) information.

Table 18

Fear Scale

CDS	Yes Mean (*SD*)	No Mean (*SD*)	*t* test	*p*-value
Empathetic				
Interpersonal	15.99 (5.00)	14.69 (5.14)	1.79	.08
Personal	16.04 (5.17)	14.45 (4.84)	2.17	.02*
Factual				
Sexual	16.75 (4.79)	14.87 (5.12)	2.38	.02*
Professional	15.32 (5.14)	15.78 (4.96)	-.52	.61
Success	16.17 (5.00)	14.30 (5.04)	2.57	.01**
Attitude	16.19 (5.20)	14.98 (5.00)	1.63	.11

* denotes statistical significance at the .05 level of significance. ** denotes statistical significance at the .01 level of significance.

The impact of the counselor's empathetic interpersonal disclosure on the average ESDS scores is presented in Table 19. With the exception of calmness, all average ESDS scale scores were higher when the counselor was interpersonal. There were statistically significant differences in the Jealousy ($t(196) = 1.98$, $p < .05$) and Anger ($t(196) = 2.32$, $p = .02$) and Apathy ($t(196) = 2.02$, $p < .05$) participant disclosures. On average, Jealousy scored higher when the counselor was classified as Interpersonal ($M = 14.42$, $SD = 5.22$) than when the counselor was classified as not being Interpersonal ($M = 12.91$, $SD = 5.45$). The average Anger score was higher when the counselor was classified as Interpersonal ($M = 16.15$, $SD = 4.98$) as compared to when the counselor was not classified as Interpersonal ($M = 14.51$, SD =4 .93). The average Apathy score was higher when the counselor was classified as Interpersonal ($M = 15.21$, $SD = 4.86$) compared to when the counselor was not Interpersonal ($M = 13.73$, $SD = 5.54$).

Table 19

Counselor Empathetic Interpersonal Disclosure

ESDS scale	Counselor empathetic: Interpersonal Yes (n = 110) Mean (*SD*)	 No (n = 88) Mean (*SD*)	*t* test	*p*-value
Depression	17.23 (4.73)	16.40 (4.60)	1.23	.22
Happiness	15.97 (4.95)	14.51 (5.62)	1.94	.06
Jealousy	14.42 (5.22)	12.91 (5.45)	1.98	.049*
Anxiety	17.01 (4.79)	16.41 (4.42)	.90	.37
Anger	16.15 (4.98)	14.51 (4.93)	2.32	.02*
Calmness	13.82 (4.68)	14.01 (5.38)	1.13	.26
Apathy	15.21 (4.86)	13.73 (5.54)	2.02	.045*
Fear	15.99 (5.00)	14.69 (5.14)	1.79	.08
ESDS total	126.80 (33.35)	117.17 (35.73)	1.96	.052

* denotes statistical significance at the .05 level of significance.

Table 20 presents the summary of ESDS scores by the counselor being classified as Personal. Overall, there was a statistically significant difference in the average ESDS scale score for counselors classified as Empathetic Personal compared with counselors that were not classified as Empathetic Personal ($t(196) = 2.09$, $p = .02$). With the exception of Depression, Anxiety, Calmness, and Apathy, all average ESDS scales were statistically significant ($p < .05$). There was a statistically significant average difference in the Happiness. The mean Happiness difference between the Empathetic Personal counselor and the non-Empathetic Personal counselor was 2.79. There was a statistically significant difference average difference with the Jealousy scale. On average, the Empathetic Personal Counselors had a higher score than non-Empathetic Personal Counselors, the mean average difference was 1.61. There was a statistically significant average difference in the Anger scale scores. On average, Empathetic Personal counselors had participants scoring higher on the Anxiety scale than the non-Empathetic

Personal counselors. The mean difference was 1.66. There was a statistically significant difference in the Fear score. On average, participants with Empathetic Personal counselors scored higher than participants with non-Empathetic Personal counselors. The mean difference was 1.59.

Table 20

Counselor Empathetic Personal Disclosure

ESDS scale	Counselor empathetic: Personal Yes (n = 120) Mean (SD)	No (n = 78) Mean (SD)	t test	p-value
Depression	17.08 (4.72)	16.51 (4.62)	.83	.41
Happiness	16.97 (5.05)	14.18 (5.49)	2.48	.007**
Jealousy	14.38 (5.19)	12.77 (5.51)	2.09	.02*
Anxiety	17.05 (4.73)	16.27 (4.45)	1.61	.12
Anger	16.08 (4.84)	14.42 (5.14)	2.29	.01*
Calmness	14.85 (4.81)	13.86 (5.27)	1.36	.09
Apathy	15.09 (5.05)	13.73 (5.38)	1.34	.09
Fear	16.04 (5.17)	14.45 (4.84)	2.17	.02*
ESDS total	126.63 (33.97)	116.19 (35.02)	2.09	.02 *

* denotes statistical significance at the .05 level of significance. ** denotes statistical significance at the .01 level of significance.

Table 21 provides the summary of ESDS average scales scores by the presence or absence of counselors' Factual Sexual information. Overall, there was a statistically significant difference in the average ESDS scale score for counselors classified as Factual Sexual compared with counselors that were not classified as Factual Sexual ($t(196) = 2.21, p =. 02$). All ESDS scales were statistically significant ($p < .05$) with the exception of Depression, Anxiety, and Anger. There was a statistically significant difference in participant's Happiness ($t(196) = 1.99, p < .05$). On average, participants of Factual Sexual counselors had a higher score on Happiness than non-Factual Sexual counselors

(*M* = 16.49, *SD* = 4.72 *vs.* *M* = 14.85, *SD* = 5.45). There was a statistically significant difference in the average Jealousy scores of the participants ($t(196) = 3.25$, $p = .001$). On average, the Anxiety score of Factual Sexual counselor participants was (*M* = 15.65, *SD* = 5.13) compared to the average score of participants with counselors classified as non-Factual Sexual (*M* = 12.98, *SD* = 5.27). There was a statistically significant difference in Calmness ($t(196) = 2.11$, $p = .04$). On average participants with counselors classified as Factual Sexual had higher scores (*M* = 15.63, *SD* = 4.58) than the non-Factual Sexual counselors (*M* = 13.99, *SD* = 5.11). There was a statistically significant difference in participant Apathy. On average participants with a Factual Sexual counselor had higher Apathy scores (*M* = 16.05, *SD* = 4.56) than non-Factual Sexual counselors (*M* = 13.95, *SD* = 5.35). There was a statistically significant difference in Fear ($t(196) = 2.38$, $p = .02$). Participants with a Factual Sexual counselor had a higher average Fear score (*M* = 16.75, *SD* = 4.79) than non-Factual Sexual counselors (*M* = 14.87, *SD* = 5.12).

Table 21

Counselor Factual Sexual Disclosure

ESDS scale	Counselor factual: Sexual Yes (n = 57) Mean (SD)	 No (n = 141) Mean (SD)	t test	p-value
Depression	17.12 (4.59)	16.74 (4.73)	.51	.61
Happiness	16.49 (4.72)	14.85 (5.45)	1.99	.05*
Jealousy	15.65 (5.13)	12.98 (5.27)	3.25	.001***
Anxiety	17.04 (4.56)	16.62 (4.67)	.57	.57
Anger	16.25 (4.83)	15.09 (5.07)	1.47	.14
Calmness	15.63 (4.58)	13.99 (5.11)	2.11	.04*
Apathy	16.05 (4.56)	13.95 (5.35)	2.61	.01*
Fear	16.75 (4.79)	14.87 (5.12)	2.38	.02*
ESDS total	130.98 (32.13)	119.10 (35.18)	2.21	.02*

* denotes statistical significance at the .05 level of significance. ** denotes statistical significance at the .01 level of significance. *** denotes statistical significance at the .001 level of significance.

The summary ESDS scores for counselors who are Factual and Professional are provided in Table 22. There were no statistically significant differences in the average ESDS scale scores. Thus, counselors who were Factual Professional did not have a difference in the scales of the ESDS when compared to counselors who not Factual Professional.

Table 22

Counselor Factual Professional Disclosure

ESDS scale	Counselor factual: Professional Yes (n = 157) Mean (*SD*)	No (n = 41) Mean (*SD*)	t test	p-value
Depression	16.88 (4.75)	16.76 (4.44)	.15	.88
Happiness	15.36 (5.24)	15.17 (5.53)	.21	.84
Jealousy	13.48 (5.53)	14.78 (5.53)	-1.39	.18
Anxiety	16.74 (4.62)	16.73 (4.72)	.02	.99
Anger	15.29 (4.92)	15.93 (5.40)	-.72	.47
Calmness	14.45 (4.90)	14.49 (5.46)	-.04	.97
Apathy	14.32 (5.10)	15.44 (5.60)	-1.22	.22
Fear	15.32 (5.14)	15.78 (4.96)	-.52	.61
ESDS total	121.85 (34.05)	125.07 (37.30)	-.53	.60

The comparison of counselors who were classified as Factual Success and non-Factual Success is provided in Table 23. Overall, there was a statistically significant difference in the average ESDS scale score for counselors classified as Factual Success compared with counselors that were not classified as Factual Success ($t(196) = 3.42$, $p < .001$). Comparing counselors classified as Success with counselors not classified as success, all ESDS scales were statistically significant different ($p < .05$).

Table 23

Counselor Factual Success Disclosure

ESDS scale	Counselor factual: Success Yes (n = 118) Mean (SD)	 No (n = 80) Mean (SD)	t test	p-value
Depression	17.78 (4.46)	15.49 (4.69)	3.48	< .001***
Happiness	16.17 (5.01)	14.08 (5.48)	2.78	.006**
Jealousy	14.68 (5.31)	12.38 (5.17)	3.03	.003**
Anxiety	17.60 (4.43)	15.48 (4.66)	3.25	.001***
Anger	16.19 (4.73)	14.29 (5.24)	2.67	.008**
Calmness	15.26 (4.79	13.28 (5.12)	2.79	.006**
Apathy	15.42 (5.06)	13.29 (5.20)	2.87	.005**
Fear	16.17 (5.00)	14.30 (5.04)	2.57	.01*
ESDS total	129.27 (32.65)	112.56 (35.36)	3.42	< .001***

* denotes statistical significance at the .05 level of significance. ** denotes statistical significance at the .01 level of significance. *** denotes statistical significance at the .001 level of significance.

On average, Depression was statistically significant ($t(196) = 3.48$, $p < .001$). The average Depression score for Success was 17.78 (SD = 4.46) and non-Success was 15.49 (SD = 4.69). On average, Happiness was statistically significant ($t(196) = 2.78$, $p = .006$). The average Happiness score of Success was 16.17 (SD = 5.01) and non-Success was 14.08 (SD = 5.48). On average, Jealousy was statistically significant ($t(196) = 3.03$, $p = .003$). The average Jealousy score was 14.68 (SD = 5.31) for Success and 12.38 (SD = 5.17) for non-Success counselors. On average, Anxiety was statistically significant ($t(196) = 3.25$, $p = .001$). The average Anxiety score for Success counselors was 17.60 (SD = 4.43) and the average score for non-Success counselors was 15.48 (SD = 4.66). There was a statistically significant difference for Anger. On average the Anger scores for Success counselors was 16.19 (SD = 4.73) and 14.29 (SD = 5.24) for non-Success

counselors. There was a statistically significant difference for Calmness ($t(196) = 2.79$, $p = .006$). The average Calmness score for Success counselors was 15.26 (*SD* = 4.79) and 13.28 (*SD* = 5.20) for non-Success counselors. There was a statistically significant difference for Apathy ($t(196) = 2.87$, $p = .005$). The average Apathy score for Success counselors was 15.42 (*SD* = 5.06) and 13.29 (*SD* = 5.20). There was a statistically significant difference for Fear ($t(196) = 2.57$, $p = .01$). The average Fear score for Success was 16.17 (*SD* = 5.00) and 14.30 (*SD* = 5.04) for non-Success counselors.

The summary of counselors classified as Attitude is presented in Table 24. There was a statistically significant difference for Jealousy ($t(196) = 3.73$, $p < .001$). The average Jealousy score for Attitude counselors was 15.42 (SD = 5.21) and 12.81 (SD = 5.23) for non-Attitude counselors.

Table 24

Counselor Factual Attitude Disclosure

ESDS scale	Counselor factual: Attitude Yes (n = 71) Mean (*SD*)	No (n = 127) Mean (*SD*)	*t* test	*p*-value
Depression	16.94 (4.97)	16.80 (4.53)	.20	.84
Happiness	16.18 (5.05)	14.84 (5.39)	1.72	.09
Jealousy	15.42 (5.21)	12.81 (5.23)	3.73	< .001***
Anxiety	16.59 (4.83)	16.83 (4.53)	-.34	.73
Anger	16.37 (4.73)	14.90 (5.11)	1.99	.05*
Calmness	15.10 (4.96)	14.10 (5.02)	1.35	.18
Apathy	15.55 (4.92)	14.00 (5.31)	2.02	.05*
Fear	16.19 (5.20)	14.98 (5.00)	1.63	.11
ESDS total	128.35 (34.80)	119.26 (34.31)	1.78	.08

* denotes statistical significance at the .05 level of significance. *** denotes statistical significance at the .001 level of significance.

A summary of Empathetic disclosure of the therapist is presented in Table 25. When a counselor did not exhibit any empathetic disclosure, there was no difference in the participants' disclosure of depression or anxiety information. The counselor's disclosure of Interpersonal information increased participant disclosure of Jealousy, Anger and Apathy. When the counselor disclosed Personal information, participants disclosed more Happiness, Jealousy, Anger, and Fear.

Table 25

Empathetic Disclosure of the Therapist

	Empathetic	
	Interpersonal	Personal
Depression		
Happiness		●
Jealousy	●	●
Anxiety		
Anger	●	●
Calmness		
Apathy	●	
Fear		●

Table 26 provides a summary of the type of concepts participants discuss with their therapists more when the counselor discloses factual information. When the counselor discloses success information, the participant discussed each concept more than when the counselor did not disclose success information. When the counselor disclosed sexual information participants discussed happiness, jealousy, calmness, apathy, and fear more than participants who attended counselors who did not disclose sexual information. Counselor's disclosure of Attitude had a difference in participants discussing more Jealousy, Anger and Apathy. In contrast, counselors disclosing

professional information did not have a difference in the participants' discussion of any scale concepts.

Table 26

Factual Disclosure of the Therapist

	Counselor disclosure: Factual			
Participant disclosure	Sexual	Professional	Success	Attitude
Depression			●	
Happiness	●		●	
Jealousy	●		●	●
Anxiety			●	
Anger			●	●
Calmness	●		●	
Apathy	●		●	●
Fear	●		●	

Research Question 2

RQ2—Quantitative: Is client willingness to self-disclose related to the gender of therapist self-disclosure?

H0: There is no difference in client willingness to self-disclose based on the gender of therapist self-disclosure.

H1: There is a difference in client willingness to self-disclose based on the gender of therapist self-disclosure.

The following tables provide the comparison of the ESDS scales by gender of the therapist. There were no statistically significant averages differences in any of the ESDS scales.

Table 27

Counselor Gender and Its Connection to Client Willingness to Self-Disclose

ESDS scale	Gender Female (n = 133) Mean (*SD*)	 Male (n = 56) Mean (*SD*)	*t* test	*p*-value
Depression	17.32 (4.62)	16.13 (4.41)	1.65	.10
Happiness	15.62 (5.33)	14.98 (5.12)	.77	.45
Jealousy	13.89 (5.57)	13.63 (4.84)	.32	.75
Anxiety	17.18 (4.53)	15.96 (4.44)	1.70	.09
Anger	15.62 (5.10)	15.29 (4.76)	.42	.68
Calmness	14.62 (5.20)	14.41 (4.50)	.26	.80
Apathy	14.56 (5.18)	14.96 (5.00)	-.49	.63
Fear	15.52 (5.20)	15.46 (4.54)	.07	.95
ESDS total	124.34 (34.86)	120.82 (32.33)	.65	.52

To examine gender differences in classification of Factual and Empathetic self-disclosures of the therapists, chi-squares were conducted. There was a statistically significant difference in the proportion of female therapist classifying as Factual Professional and male therapists classified as Factual Professional (χ^2 (1) = 4.37, p = .04). Proportionately more males classified as Factual Professional (89%) than females (76%). No other classifications were statistically significant (see Table 28).

Table 28

Comparison of Counselor Disclosure Scale by Gender of Therapist

CDS	Therapist gender Female (n = 133) n (%)	 Male (n = 56) n (%)	χ^2-test	*p*-value
Empathetic—Interpersonal	74 (56)	32 (57)	.04	.85
Empathetic—Personal	78 (59)	38 (68)	1.41	.24
Factual—Sexual	35 (26)	20 (36)	1.69	.19
Factual—Professional	101 (76)	50 (89)	4.37	.04*
Factual—Success	82 (62)	31 (55)	.65	.42
Factual—Attitude	49 (37)	20 (36)	.02	.88

* denotes statistical significance at the .05 level of significance.

Research Question 3

RQ3—Quantitative: Is client willingness to self-disclose related to the interaction effect between empathetic, factual, or no therapist self-disclosures and the therapist's gender?

H_0: There is no interaction effect in client willingness to self-disclose between empathetic, factual, or no therapist self-disclosures and the therapist's gender.

H_1: There is an interaction effect in client willingness to self-disclose between empathetic, factual, or no therapist self-disclosures and the therapist's gender.

Because of the specific nature of the independent variables (i.e., categorical for therapist self-disclosure with three levels, and categorical for the gender of the therapist with two levels, as well as the dependent variable which will be continuous from 0 to 4 on a Likert scale), the statistic that was used to analyze the data was a two-way ANOVA (Frankfort-Nachmias, & Leon-Guerrero, 2015; Liu, 2021; Warner, 2013). Last, the data collected was exported to a statistical software program called the Statistical Package for the Social Sciences (SPSS) (Wagner, 2017) for analysis.

Testing of Assumptions

Normality was tested using the Shapiro-Wilks tests. The Shapiro-Wilks test statistic and p-values are presented in Tables 29 through 47. The majority of Shapiro-Wilks tests were not statistically significant ($p > .05$). Thus, they did not violate the assumption of normality. The scales that were statistically significant were examined

further using the Q-Q plots. The Q-Q Plots did not present extreme violations of normality. In addition, the ANOVA is robust to the violation of normality assumption.

Table 29

Normality Test for Empathetic Impersonal: No

	Empathetic impersonal: No			
	Female		Male	
ESDS	Shapiro-Wilks	*p*-value	Shapiro-Wilks	*p*-value
Depression	0.97	0.11	0.94	0.17
Happiness	0.97	0.09	0.97	0.76
Jealousy	0.94	0.01	0.95	0.30
Anxiety	0.98	0.26	0.92	0.07
Anger	0.98	0.26	0.92	0.06
Calmness	0.97	0.14	0.95	0.26
Apathy	0.96	0.06	0.97	0.57
Fear	0.98	0.26	0.97	0.56

Table 30

Normality Test for Empathetic Impersonal: Yes

	Empathetic impersonal: Yes			
	Female		Male	
ESDS	Shapiro-Wilks	*p*-value	Shapiro-Wilks	*p*-value
Depression	0.97	0.05	0.97	0.39
Happiness	0.96	0.01	0.98	0.71
Jealousy	0.97	0.06	0.97	0.46
Anxiety	0.97	0.06	0.98	0.87
Anger	0.96	0.02	0.97	0.6
Calmness	0.96	0.04	0.91	0.02
Apathy	0.98	0.29	0.93	0.05
Fear	0.97	0.1	0.95	0.11

Table 31

Normality Test for Empathetic Personal: No

	Empathetic personal: No			
	Female		Male	
ESDS	Shapiro-Wilks	*p*-value	Shapiro-Wilks	*p*-value
Depression	0.98	0.46	0.97	0.72
Happiness	0.95	0.02	0.93	0.18
Jealousy	0.93	0.04	0.84	0.005
Anxiety	0.97	0.28	0.94	0.34
Anger	0.96	0.08	0.96	0.51
Calmness	0.96	0.05	0.9	0.05
Apathy	0.96	0.06	0.96	0.58
Fear	0.97	0.29	0.94	0.32

Table 32

Normality Test for Empathetic Personal: Yes

	Empathetic personal: Yes			
	Female		Male	
ESDS	Shapiro-Wilks	*p*-value	Shapiro-Wilks	*p*-value
Depression	0.96	0.02	0.93	0.02
Happiness	0.97	0.06	0.97	0.28
Jealousy	0.97	0.07	0.96	0.14
Anxiety	0.97	0.09	0.97	0.41
Anger	0.98	0.13	0.95	0.09
Calmness	0.97	0.04	0.94	0.04
Apathy	0.98	0.16	0.92	0.009
Fear	0.97	0.1	0.94	0.04

Table 33

Normality Test for Factual Sexual: No

	Factual sexual: No			
	Female		Male	
ESDS	Shapiro-Wilks	*p*-value	Shapiro-Wilks	*p*-value
Depression	0.97	0.03	0.98	0.70
Happiness	0.97	0.02	0.96	0.29
Jealousy	0.96	0.00	0.95	0.14
Anxiety	0.98	0.07	0.98	0.68
Anger	0.97	0.03	0.96	0.21
Calmness	0.97	0.01	0.97	0.31
Apathy	0.97	0.02	0.96	0.29
Fear	0.98	0.07	0.96	0.25

Table 34

Normality Test for Factual Sexual: Yes

	Factual sexual: Yes			
	Female		Male	
ESDS	Shapiro-Wilks	*p*-value	Shapiro-Wilks	*p*-value
Depression	0.96	0.23	0.87	0.01
Happiness	0.95	0.10	0.94	0.19
Jealousy	0.95	0.09	0.91	0.08
Anxiety	0.97	0.32	0.94	0.23
Anger	0.96	0.22	0.94	0.21
Calmness	0.96	0.17	0.91	0.07
Apathy	0.98	0.80	0.89	0.03
Fear	0.96	0.19	0.89	0.03

Table 35

Normality Test for Factual Professional: No

	Factual professional: No			
	Female		Male	
ESDS	Shapiro-Wilks	*p*-value	Shapiro-Wilks	*p*-value
Depression	0.97	0.55	0.98	0.94
Happiness	0.96	0.35	0.99	0.99
Jealousy	0.95	0.19	0.80	0.05
Anxiety	0.98	0.65	0.85	0.16
Anger	0.96	0.24	0.94	0.67
Calmness	0.95	0.14	0.93	0.57
Apathy	0.95	0.11	0.95	0.74
Fear	0.98	0.77	0.91	0.42

Table 36

Normality Test for Factual Professional: Yes

	Factual professional: Yes			
	Female		Male	
ESDS	Shapiro-Wilks	*p*-value	Shapiro-Wilks	*p*-value
Depression	0.97	0.02	0.96	0.09
Happiness	0.97	0.01	0.97	0.26
Jealousy	0.96	0.00	0.97	0.21
Anxiety	0.97	0.04	0.97	0.33
Anger	0.98	0.06	0.96	0.11
Calmness	0.97	0.02	0.95	0.04
Apathy	0.98	0.11	0.95	0.02
Fear	0.97	0.04	0.96	0.07

Table 37

Normality Test for Factual Success: No

	Factual success: No			
	Female		Male	
ESDS	Shapiro-Wilks	*p*-value	Shapiro-Wilks	*p*-value
Depression	0.97	0.22	0.95	0.29
Happiness	0.97	0.16	0.98	0.84
Jealousy	0.95	0.02	0.94	0.15
Anxiety	0.98	0.47	0.95	0.29
Anger	0.96	0.07	0.97	0.61
Calmness	0.97	0.22	0.94	0.18
Apathy	0.97	0.16	0.96	0.33
Fear	0.97	0.29	0.97	0.60

Table 38

Normality Test for Factual Success: Yes

	Factual success: Yes			
	Female		Male	
ESDS	Shapiro-Wilks	*p*-value	Shapiro-Wilks	*p*-value
Depression	0.97	0.03	0.95	0.16
Happiness	0.96	0.01	0.96	0.32
Jealousy	0.96	0.02	0.97	0.65
Anxiety	0.98	0.10	0.97	0.64
Anger	0.97	0.03	0.96	0.22
Calmness	0.97	0.04	0.94	0.09
Apathy	0.97	0.09	0.95	0.12
Fear	0.97	0.06	0.94	0.07

Table 39

Normality Test for Factual Attitude: No

	Factual attitude: No			
	Female		Male	
ESDS	Shapiro-Wilks	*p*-value	Shapiro-Wilks	*p*-value
Depression	0.97	0.04	0.96	0.20
Happiness	0.96	0.02	0.97	0.45
Jealousy	0.95	0.00	0.95	0.12
Anxiety	0.97	0.03	0.97	0.44
Anger	0.96	0.02	0.96	0.25
Calmness	0.97	0.04	0.96	0.17
Apathy	0.97	0.02	0.96	0.18
Fear	0.98	0.14	0.96	0.24

Table 40

Normality Test for Factual Attitude: Yes

	Factual attitude: Yes			
	Female		Male	
ESDS	Shapiro-Wilks	*p*-value	Shapiro-Wilks	*p*-value
Depression	0.96	0.11	0.90	0.05
Happiness	0.97	0.21	0.97	0.73
Jealousy	0.97	0.15	0.94	0.23
Anxiety	0.97	0.24	0.94	0.28
Anger	0.96	0.08	0.95	0.42
Calmness	0.96	0.09	0.94	0.19
Apathy	0.97	0.28	0.91	0.07
Fear	0.97	0.17	0.92	0.08

The Levene’s test was used to assess the homogeneity of variance for each ANOVA model (see Table 41). There were no models that violated the assumption of homogeneity.

Table 41

Levene's Test for Homogeneity of Variance Analysis of Variance

ESDS scale	Personal	Interpersonal	Sexual	Professional	Success	Attitude
Depression	0.83	0.7	0.59	0.58	0.8	0.16
Happiness	0.52	0.54	0.25	0.32	0.55	0.67
Jealousy	0.21	0.3	0.29	0.29	0.18	0.31
Anxiety	0.41	0.28	0.84	0.45	0.4	0.64
Anger	0.42	0.39	0.69	0.37	0.65	0.28
Calmness	0.07	0.07	0.1	0.06	0.09	0.14
Apathy	0.5	0.33	0.22	0.25	0.72	0.21
Fear	0.26	0.43	0.39	0.18	0.31	0.27

Interaction Effects of Counselor Self-Disclosures and the Respondent's Answers on the Emotional Self-Disclosure Scale

The interaction effect of counselor's Empathetic Personal disclosure and the counselor's gender is presented in Table 42. The overall models for Happiness were statistically significant ($p = .049$). However, the interaction effect did not significantly contribute to the model ($p > .05$).

Table 42

Counselor Empathetic: Personal Disclosure

	Empathetic: Personal					
	Yes		No		Overall model	
ESDS scale	Female	Male	Female	Male	*F*	*p*-value
Depression	17.65 (.52)	16.00 (.74)	16.86 (.62)	16.39 (1.08)	1.26	0.29
Happiness	15.96 (.59)	16.21 (.84)	15.15 (.70)	12.39 (1.23)	2.67	0.049 [a]
Jealousy	14.58 (.61)	14.08 (.87)	12.93 (.72)	12.67 (1.26)	1.34	0.26
Anxiety	17.46 (.51)	16.18 (.73)	16.78 (.61)	15.50 (1.06)	1.29	0.28
Anger	16.18 (.56)	15.90 (.81)	14.82 (.67)	14.00 (1.17)	1.46	0.23
Calmness	14.76 (.57)	15.05 (.81)	14.42 (.68)	13.06 (1.18)	0.72	0.54
Apathy	15.13 (.58)	14.97 (.83)	13.76 (.69)	14.98 (.83)	0.84	0.47
Fear	16.12 (.57)	16.00 (.81)	14.67 (.67)	14.33 (1.18)	1.35	0.26

[a] The interaction effect for Counselor Gender and Empathetic Personal was $F = 2.97$, $p = .09$.

The interaction effect of counselor's Empathetic Interpersonal disclosure and the counselor's gender is presented in Table 43. The overall models were not statistically significant ($p < .05$).

Table 43

Counselor Empathetic: Interpersonal Disclosure

	Empathetic: Interpersonal					
	Yes		No			
ESDS scale	Female	Male	Female	Male	*F*	*p*-value
Depression	17.77 (.53)	16.06 (.81)	16.76 (.59)	16.21 (.93)	1.46	0.23
Happiness	16.11 (.61)	15.72 (.93)	15.02 (.69)	14.00 (1.07)	1.16	0.33
Jealousy	14.55 (.62)	14.19 (.95)	13.07 (.70)	12.88 (1.09)	1.15	0.33
Anxiety	17.55 (.52)	15.81 (80)	16.71 (.59)	16.17 (.92)	1.37	0.26
Anger	16.47 (.58)	15.47 (.88)	14.54 (.65)	15.04 (1.01)	1.75	0.16
Calmness	14.97 (.58)	14.69 (.89)	14.17 (.65)	14.04 (1.02)	0.39	0.77
Apathy	15.41 (.59)	14.97 (.90)	13.51 (.66)	14.96 (1.04)	1.6	0.19
Fear	16.31 (.58)	15.47 (.88)	14.53 (.65)	15.46 (1.02)	1.4	0.24

The interaction effect of counselor's Factual Sexual disclosure and the counselor's Gender is presented in Table 44. With the exception of Jealousy and Fear, the overall models were not statistically significant ($p < .05$). The overall model for Jealousy was statistically significant ($F = 3.40$, $p = .02$). However, the interaction effect was not statistically significant ($F = .31$, $p = .58$). The overall model for Fear was statistically significant ($F = 3.07$, $p = .03$). The interaction effect was not statistically significant $F = 3.11$, $p = .08$).

Table 44

Counselor Factual: Sexual Disclosure

	Factual: Sexual					
	Yes		No			
ESDS scale	Female	Male	Female	Male	*F*	*p*-value
Depression	18.00 (.77)	15.65 (1.02)	17.08 (.46)	16.39 (.76)	1.37	0.26
Happiness	16.80 (.89)	15.90 (1.17)	15.20 (.53)	14.47 (.88)	1.31	0.27
Jealousy	16.09 (.89)	14.90 (1.18)	13.11 (.53)	12.92 (.88)	3.4	0.02
Anxiety	17.86 (.76)	15.60 (1.01)	16.94 (.46)	16.17 (.75)	1.38	0.25
Anger	16.49 (.85)	15.85 (1.12)	15.31 (.51)	14.97 (.83)	0.67	0.57
Calmness	16.06 (.84)	15.20 (1.11)	14.10 (.50)	13.97 (.83)	1.62	0.19
Apathy	16.51 (.86)	15.30 (1.13)	13.87 (.51)	14.78 (.83)	2.48	0.06
Fear	17.69 (.83)	15.45 (1.10)	14.75 (.50)	15.47 (.82)	3.07	0.03

The interaction effect was tested for ESDS scales for the Factual Professional counselor disclosure (see Table 45). There were no statistically significant models.

Table 45

Counselor Factual: Professional Disclosure

	Factual: Professional					
	Yes		No			
ESDS scale	Female	Male	Female	Male	*F*	*p*-value
Depression	17.31 (.45)	16.40 (65)	17.38 (.81)	13.83 (1.86)	1.47	0.22
Happiness	15.65 (.53)	15.30 (.75)	15.53 (.93)	12.33 (2.15)	0.76	0.52
Jealousy	13.53 (.53)	13.68 (.76)	15.06 (.995)	13.17 (2.19)	0.72	0.54
Anxiety	17.17 (.45)	16.22 (.64)	17.22 (.80)	13.83 (1.84)	1.46	0.23
Anger	15.38 (.50)	15.42 (.71)	16.38 (.89)	15.38 (.50)	0.49	0.69
Calmness	14.63 (.50)	14.58 (.71)	14.56 (.89)	13.00 (2.05)	0.2	0.9
Apathy	14.26 (.51)	14.98 (.73)	15.53 (.91)	14.83 (2.10)	0.58	0.63
Fear	15.43 (.50)	15.44 (.71)	15.81 (.89)	15.67 (2.06)	0.05	0.98

The interaction effect of counselor gender and Factual Success disclosure was assessed and presented in Table 46. The overall models were not statistically significant in the following ESDS scales: Happiness, Anger, Calmness, Apathy and Fear. There was a statistically significant overall model for the Depression scale ($F = 4.75$, $p =. 003$). However, the interaction effect was not statistically significant ($F =2 .23$, $p = .14$). The ESDS Jealousy scale had a statistically significant overall model. The interaction effect was not statistically significant ($F = .09$, $p = .76$). The ESDS Anxiety scale was statistically significant for the overall model ($F = 4.14$, $p = .007$). The interaction effect of the counselor gender and the Factual Success disclosure was not statistically significant ($F = 1.74$, $p = .19$).

Table 46

Counselor Factual: Success Disclosure

	Factual: Success					
	Yes		No		Overall Model	
ESDS scale	Female	Male	Female	Male	*F*	*p*-value
Depression	18.34 (.49)	16.36 (.80)	15.69 (.62)	15.84 (.89)	4.753	0.003
Happiness	16.39 (.58)	15.48 (.94)	14.39 (.73)	14.36 (1.05)	1.944	0.12
Jealousy	14.68 (.58)	14.77 (.95)	12.63 (.74)	12.20 (1.06)	2.72	0.046
Anxiety	18.09 (.49)	16.19 (.79)	15.71 (.62)	15.68 (.88)	4.14	0.007
Anger	16.37 (.55)	15.71 (.89)	14.41 (.69)	14.76 (.99)	1.86	0.14
Calmness	15.23 (.55)	15.45 (.89)	13.63 (.69)	13.12 (.99)	2.15	0.1
Apathy	15.31 (.56)	15.68 (.91)	13.37 (.71)	14.08 (1.02)	2.06	0.11
Fear	16.44 (.55)	15.42 (.89)	14.04 (.69)	15.52 (.99)	2.47	0.06

The interaction effect of the Counselor Gender and the Factual Attitude disclosure was tested and presented in Table 47. There were no statistically significant overall models ($p < .05$), with the exception of the ESDS Jealousy scale. The overall model for Jealousy was statistically significant ($F = 3.45$, $p = .02$). The interaction effect in the model was not statistically significant ($F = 0.1$, $p = .75$).

Table 47

Counselor Factual: Attitude Disclosure

	Factual: Attitude					
	Yes		No			
ESDS scale	Female	Male	Female	Male	*F*	*p*-value
Depression	17.18 (.65)	16.40 (1.02)	17.41 (.50)	15.97 (.76)	0.96	0.41
Happiness	15.98 (.75)	16.60 (1.17)	15.42 (.570	14.08 (.88)	1.3	0.28
Jealousy	15.39 (.75)	15.50 (1.18)	13.02 (.57)	12.58 (.88)	3.45	0.02
Anxiety	16.86 (.65)	15.90 (1.01)	17.37 (.49)	16.00 (.75)	1.09	0.36
Anger	16.20 (.71)	16.80 (1.11)	15.27 (.54)	14.44 (.83)	1.38	0.25
Calmness	15.00 (.72)	15.60 (1.12)	14.39 (.55)	13.75 (.83)	0.76	0.52
Apathy	15.43 (.73)	15.85 (1.14)	14.06 (.56)	14.47 (.85)	1.13	0.34
Fear	16.25 (.72)	16.35 (1.12)	15.10 (.55)	14.97 (.84)	0.87	0.46

Summary

The first hypothesis examined whether client willingness to self-disclose was related to the type of therapist self-disclosure. Counselors who self-disclosed Factual Success had a statistically significant difference on clients discussing their depression on the ESDS. Concerning the Happiness Scale, on average, participants disclosed happiness more when the counselor self-disclosed Personal information. In addition, when the counselor disclosed interpersonal, personal, sexual, success and attitude information, participants scored higher on the Jealousy scale. Concerning the Anxiety scale clients spoke more about their anxiety score when the therapist disclosed Success than when they did not, and when the therapist self-disclosed Success clients scored higher on the Anger scale. On the other hand, when the therapist self-disclosed Success, clients responded higher on the Calmness scale. Last, the Apathy scale scores increased significantly when the therapist disclosed Interpersonal, Sexual, Success, and Attitude

information. On the Fear scale there were statistically significant differences when the counselor disclosed Personal, Sexual, and Success disclosures.

Counselors who self-disclosed empathetic responses produced elicited significant differences on most of the scales concerning depression, happiness, jealousy, anxiety, anger, calmness, apathy, or fear on the ESDS. The counselor's empathetic Interpersonal disclosure on the average ESDS scores with the exception of calmness were higher when the counselor was interpersonal with the client.

The second research question examined whether client willingness to self-disclose is related to the gender of therapist. There were no statistically significant average differences in any of the ESDS scales concerning depression, happiness, jealousy, anxiety, anger, calmness, apathy, or fear. On the other hand, gender differences in classification of Factual and Empathetic self-disclosures of the therapists were statistically significant. More males classified as Factual Professional than females.

Last, the third research question explored whether client willingness to self-disclose related to the interaction effect between empathetic, factual, or no therapist self-disclosures and the therapist's gender on a client's willingness to self-disclose. The Shapiro-Wilks tests were not statistically significant; albeit, the scales that were statistically significant were examined further using the Q-Q plots, and there was no significant difference for Factual and Empathetic self-disclosures of the therapists and their gender on the ESDS scales concerning depression, happiness, jealousy, anxiety, anger, calmness, apathy, or fear.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to discover if there was a relationship between a therapist's empathetic, factual, or no self-disclosures on a client's willingness to self-disclose during a therapeutic session. Another purpose of this study was to determine if the gender of the therapist and their empathetic, factual, or no self-disclosures are connected to a client's willingness to self-disclose during therapeutic sessions. Last, I wanted to determine if there were any interaction connections between empathetic, factual, or no therapist self-disclosures and the therapist's gender on a client's willingness to self-disclose, as well as the client' gender. Participants were volunteers between the ages of 18 and 60, were fluent in English, had been in therapy for at least three to four sessions within the past 3 to 4 months, and lived in the continental United States. Participants who volunteered spent 20 minutes on average taking the CDS and the ESDS. There were several strong correlations between type of counselor self-disclosure, counselor gender, and the gender of the client and their willingness to self-disclose during a therapy session.

Interpretation of the Findings

As stated in Chapter 2, decades of research scholars have examined the connections between therapist self-disclosure and a client's willingness to self-disclose during a therapy session (Audet, 2011; Bottrill et al., 2010; Danzer, 2019; Dean, 2010; Henretty & Levitt, 2010; Jourard, 1959, 1961, 1963, 1970; Jourard & Landsman, 1960). However, no studies have explored the type of therapist self-disclosure (empathetic,

factual, or none) and the gender of the therapist on a client's willingness to self-disclose during a therapeutic session. Consequently, I attempted to fill two gaps in this research. There is a current need to determine what types of therapist self-disclosures may engage a client to self-disclose. According to Dutton (2018), appropriate therapist self-disclosures are paramount for client self-disclosures. Liddon et al. (2018) found that some clients self-disclose more or less during therapy because of the therapist's gender. This study is unique because it addresses a gap in the research concerning the efficacy of a therapist's type of self-disclosure and the therapist's gender on the client's willingness to self-disclose. Closing this gap will allow for further research in this field, and the results can be implemented by practitioners in the field of clinical psychology to facilitate self-disclosures from their clients (Burkholder et al., 2016). The results of this study suggested that certain types of therapist self-disclosure were connected to a client's willingness to self-disclose; however, the gender of the therapist was not associated with a client's willingness to self-disclose.

Type of Therapist Self-Disclosure

A chi-square statistic was incorporated to determine if there were any connections between the type of therapist self-disclosure and the interaction effects of the type of therapist self-disclosure as independent variables and a client's willingness to self-disclose as the dependent variable. The type of therapist self-disclosure was measured by using the CDS (Hendrick, 1990), and to measure the client's willingness to self-disclose, the ESDS (Snell et al., 2013) was incorporated. Several findings were supportive of Lee (2014), Paine et al. (2010), and Henretty and Levitt (2010).

Empathetic Therapist Self-Disclosures

There were several significant findings concerning empathetic therapist self-disclosures on the CDS and a client's willingness to self-disclose on the ESDS. In Table 12, on the average, participants disclosed more on the Happiness Scale of the ESDS when the therapist disclosed Empathetic Personal disclosures on the CDS. In other words, most people may want to be happier than sad, and when someone talks about their own happiness, they tend to be willing to talk more about happiness via the concept of group think, according to Janis (1982). Concerning the Jealousy Scale on the ESDS, when the therapist self-disclosed Empathetic Personal and Empathetic Personal disclosures, clients strongly disclosed their feelings of Jealousy. The reader is cautioned here because it may depend on exactly what the counselor was personally disclosing, its intensity, and the client's personal experiences, which may have been recent and devastating to them (Mauss et al., 2005). On the average, clients scored higher on the Apathy Scale (Table 17) of the CDS when the therapist provided Empathetic Interpersonal disclosures. If the therapist discussed their own feeling of apathy, then the clients may have felt validated and reinforced; consequently, they were willing to open up (Rogers, 1951). When measuring on the Fear Scale (Table 18), clients disclosed more as the therapist self-disclosed Empathetic Personal feeling to the clients. Again, people relate better when someone else has had a similar experience (Cacioppo & Freberg, 2017).

Factual Therapist Self-Disclosures

Counselors self-disclosing Factual Success on the CDS showed an increase in a client's willingness to self-disclose their feelings on the Depression Scale (Table 11) of

the ESDS. This outcome supports the work of Danzer (2019) and Henretty and Levitt (2010). It may mean that, when a therapist self-discloses factual information about success, it may have a motivating effect on a client's willingness to self-disclose about their depression because the therapist avoided any discussion of their depression, which could have had a negative effect on the client's willingness to self-disclose their feelings of depression. In other words, "misery loves company," which in this case was avoided (Miller & Dollard, 1941). In Table 12, when therapists self-disclosed Factual Sexual and Factual Success information, clients tended to self-disclose more on the Happiness Scale on the ESDS, perhaps because factual disclosures on the part of the therapist engendered a coterminous, supportive reaction to feeling good about their own feelings, which supports the positive reinforcement theory espoused by Beck (2011). Also, clients self-disclosed more on the Anxiety Scale of the ESDS when the counselor self-disclosed Factual Success (Table 14) on the CDS, probably for the same reasons discussed above. If clients know something about a therapist's success disclosures, they may be willing to talk about their anxiety in hopes to find ways to reduce it (Beck, 2011; Rogers, 1951, 1960).

Concerning a client's response on the Anger Scale (Table 15) of the ESDS, clients were more willing to self-disclose their anger when the therapist discussed Factual Success on the CDS. Again, avoiding empathy in this case allowed clients to discuss their own anger in the hope that the therapist had a solution to reducing the client's anger issues (Beck, 2011). Again, in Table 16, when the therapist self-disclosed Factual Success, clients disclosed more on the Calmness Scale, perhaps for the same reasons

stated above. As related on the Apathy Scale of the CDS in Table 17, all therapist Factual Sexual, Factual Professional, Factual Success, and Factual Attitude self-disclosures engendered the client's willingness to discuss their sense of Apathy on the CDS. It seems that when the therapist provides facts instead of empathy related to the Apathy Scale, clients may feel more validated with facts than empathetic emotion because of their own apathy; this supports the avoidance theory of Miller and Dollard (1941).

Gender of the Therapist and Self-Disclosure

To discover if there would be any therapist gender differences when self-disclosing and its connection to a client's willingness to self-disclose, chi-squares were conducted. The only significant difference between the genders was that male practitioners tended to self-disclose Factual Professional more than female practitioners. No differences were found concerning the gender of the therapists and a client's willingness to self-disclose on the EDSD. The culture of American people has changed over the decades. Many people are no longer concerned about whether a medical doctor, dentist, or therapist is male or female, as they might have been in the early part of the 20th century (Fiske, 2014).

Interaction Effects Between Empathetic, Factual, or No Therapist Self-Disclosures and the Therapist's Gender

Because the independent variables were of a specific nature (i.e., categorical for therapist self-disclosure with three levels, and categorical for the gender of the therapist with two levels, and the dependent variable, which was continuous from 0 to 4 on a Likert scale), the statistic that was used to analyze the data was a two-way ANOVA

(Warner, 2013). Normalcy was tested via the Shapiro-Wilks tests. The majority of the Shapiro-Wilks tests were not statistically significant. Again, American attitudes and culture have changed over the past few decades (Fiske, 2014).

Limitations of the Study

As with any scientific, empirical study, there were limitations or possible internal and external confounding variables (Babbie, 2017; Burkholder et al., 2016). This section presents the possible limitations of the present study.

Limitations of External Validity

There are several factors the reader should be aware of concerning the generalizability of the results from this study. First, the COVID-19 outbreak has affected many lives within and outside of the United States. Many people have relied on the Internet to work from home, including counseling via Zoom. In addition, the survey for this study was done via SurveyMonkey and not in person. The results may not be as applicable when clients meet with a therapist in vivo because body language and facial expression are more noticeable when in person. Also, the physical environment of the office is different from being at home. Clients who drive to a therapist's office may encounter traffic problems, which could also alter whether or not they are more willing to self-disclose when not as stressed from travel.

Limitations of Internal Validity

Although the Shapiro-Wilks test statistic showed no signs of a violation of normality, there were several limitations to internal validity. First, this study was done online, and the results came in rather quickly. Perhaps the respondents were in a hurry

and did not genuinely answer the questions. No awards such as a gift card were given for filling in the survey, and perhaps the volunteers thought there would be an award. Consequently, they may have filled in the survey haphazardly to get their reward faster. Perhaps they perceived the survey as a game or contest, given that many people play video games on their phone. Another concern is that the volunteers may have not been in therapy and may not have accurately filled in the demographic survey. It is also possible that the respondents did not understand the terms used on the surveys. Last, volunteers may have had different interpretations of the variables presented on the CDS and the ESDS.

Recommendations

There are recommendations arising from this study. Through this study, I attempted to close the gap concerning the gender and type of therapist self-disclosure and its relationship with a client's willingness to self-disclose. Much has changed in American society, according to Fiske et al. (2010). The next research project should include the LBTQ community of therapists and clients to determine if there are any connections between therapist self-disclosure and a client's willingness to self-disclose. Religious affiliation for both the therapist and client could be considered, which could include if the therapist wears clothing related to their position in the religious affiliation (i.e., Catholic priest or rabbi). Another thought would be to consider the effects of formal clothing or dress-down clothes worn by the therapist. Last, the next researcher could examine the age and/or degree of the therapist and its relationship to whether the client is willing to self-disclose.

Implications

Walden University has placed great emphasis on students' work and its effect on positive social change (Walden University, 2015). In all classes, positive social change is discussed; therefore, it must be of great importance to the faculty, student body, and society at large. Most people want to have more good days than not. If the *relationship competency* is developed at first with the client, according to the Competency Developmental Levels (DALs) of the NCSPP (2007, pp. 8–16), during the intake interview and developed throughout future therapy sessions with the client, the client will have many opportunities to listen to appropriate, judiciously emanated therapist self-disclosures in order to help the client open up more and self-disclose their issues. It is especially important when there are family issues involved in communication dysfunctions (Beck, 2010). Clients can learn to open up more when the therapist models self-disclosure (Bandura, 2001) and be more open to discussion with family members, friends, and coworkers.

Conclusion

The work of therapist self-disclosure during a therapy session is not over. Its founder, Jourard (1959), was the start of measuring the effects of therapist self-disclosure on client self-disclosure during a therapeutic session using the Jourard Self-Disclosure Scale he created. It contained 60 questions with six subscales. More scales need to be developed besides the ESDS, including improved reliability and validity coefficients for today's cultural climate. More people today are suffering from anxiety and depression. Therapists need to use every tool possible to cause clients talk about their personal issues

in order for them to self-improve. When that occurs, a domino effect may occur whereby the client likes themselves more and gets along better with family, friends, neighbors, and coworkers in the United States' troubled society today.

References

Ackerman, S., & Hilsenroth, M. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*, *23*(1), 1–33. https://doi.org/10.1016/s0272-7358(02)00146-0

Afek, O. (2019). Reflections on Kohut's theory of self psychology and pathological narcissism—Limitations and concerns. *Psychoanalytic Psychology*, *36*(2), 166–172.

Altman, I., & Taylor, D. (1973). *Social penetration: The development of interpersonal relationships*. Holt, Reinhart, and Winston.

American Educational Research Association, American Psychological Association, & National Council on Measurement in Education. (2014). *Standards for educational and psychological testing*. American Educational Research Association.

American Psychological Association. (2010). *American Psychological Association ethical principles of psychologists and code of conduct.*

Andrich, D. (2013). The legacies of R. A. Fisher and K. Pearson in the application of the Polytomous Rasch Model for assessing the empirical ordering of categories. *Educational and Psychological Measurement*, *73*(4), 553–580.

Aron, L. (1996). *A meeting of minds: Mutuality in psychoanalysis*. The Analytic Press.

Audet, C. (2011). Client perspectives of therapist self-disclosure: Violating boundaries or removing boundaries? *Counseling Psychology Quarterly*, *24*(2), 85–100.

Audet, C., & Everall, R. (2003). Counselor self-disclosure: Client-informed implications for practice. *Counseling and Psychotherapy Research*, *3*(3), 223–231.

Audet, C. T., & Everall, R. D. (2010). Therapist self-disclosure and the therapeutic relationship: A phenomenological study from the client perspective. *British Journal of Guidance & Counselling*, *38*(3), 327–342.

Babbie, E. (2017). *Basics of social research* (7th ed.). Cengage Learning.

Bach, D. R. (2017). The cognitive architecture of anxiety-like behavioral inhibition. *Journal of Experimental Psychology: Human Perception and Performance*, *43*(1), 18–29.

Bandura, A. (1965). Influence of a model's reinforcement contingencies on the acquisition of imitative responses. *Journal of Personality and Social Psychology*, *11*, 589–595.

Bandura, A. (1976). *Social learning theory* (1st ed.). Prentice-Hall.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Prentice Hall.

Bandura, A. (2001). Social cognitive theory of mass communication. *Media Psychology*, *3*, 265–299. https://doi.org/10.1207/S1532785XMEP0303_03

Bandura, A., & Walters, R. (1963). *Social learning and personality development*. Holt, Rinehart & Winston.

Barbeau, R. (2019). Gender and power dynamics. In G. S. Danzer (Ed.), *Therapist self-disclosure: An evidence-based guide for practitioners* (pp. 188–194. Routledge.

Beck, A. T. (1963). Thinking and depression I: Idiosyncratic content and cognitive distortions. *Archives of General Psychiatry*, *9*(1), 324–333.

Beck, A. T. (1964). Thinking and depression: II. Theory and therapy. *Archives of General Psychiatry*, *10*, 561–571.

Beck, A. T. (1991). Cognitive therapy. *American Psychologist*, *46*(4), 368–375. https://doi.org/10.1037/0003-066X.4.368

Beck, A., & Freeman, A. (1990). *Cognitive therapy of personality disorders*. Guilford Press.

Beck, J. S. (2011a). *Annual Reviews Conversations presents a conversation with Aaron T. Beck*. http://www.annualreviews.org/userimages/ContentEditor/1351004835908/AaronTBeckTranscript.pdf

Beck, J. S. (2011b). *Cognitive behavior therapy: Basics and beyond* (2nd ed.). Guilford Press.

Behn, A., Davanzo, A., Errázuriz, P. (2018). Client and therapist match on gender, age, and income: Does match within the therapeutic dyad predict early growth in the therapeutic alliance? *Journal of Clinical Psychology*, *74*(9), 1403–1421.

Bhati, K. S. (2014). Effect of client-therapist gender match on the therapeutic relationship: An exploratory analysis. *Psychological Reports: Relationships and Communications*, *115*(2), 565–583.

Bitar, G., Kimball, T., Bermudez, J., & Drew, C. (2014). Therapist self-disclosure and culturally competent case with Mexican-American court mandated clients: A phenomenological study. *Contemporary Family Therapy, 36*(3), 417-425.

Bloomgarden, A., & Mennuti, R. B. (Eds.). (2009). *Psychotherapist revealed: Therapists speak about self-disclosure in psychotherapy*. Retrieved from https://ebookcentral.proquest.com

Bottrill, S., Pistrang, N., Barker, C., & Worrell, M. (2010). The use of therapist self-disclosure: Clinical psychology trainees' experiences. *Psychotherapy Research, 20*(2), 165-180.

Bowman, D., Scogin, F., Floyd, M., & McKendree-Smith, N. (2001). Psychotherapy length of stay and outcome: A meta-analysis of the effect of therapist sex. *Psychotherapy: Theory, Research, Practice, Training, 38*(2), 142-148.

Brauer, J. R., & Tittle, C. R. (2012). Social learning theory and human reinforcement. *Sociological Spectrum, 32*(2), 157-177.

Brew, L., & Kottler, J. A. (2008). *Applied helping skills: Transforming lives*. Sage.

Bundza, K. A., & Simonson, N. R. (1973). Therapist self-disclosure: Its effect on impressions of therapist and willingness to disclose. *Psychotherapy: Theory, Research, and Practice, 10*(3), 215-217. https://doi.org/10.1037/h0087578

Burkholder, G. J., Cox, K. A., & Crawford, L. M. (2016). *The scholar-practitioner's guide to research design.* Laureate Publishing.

Cacioppo, J. T., & Freberg, L. A. (2017). *Discovering psychology: The science of the mind.* Cengage.

Cacioppo, J. T., Berntson, C. G., & Nusbaum, H. C. (2008). Neuroimaging as a new tool in the toolbox of psychological science. *Current Directions in Psychological Science*, *17*(2), 62–67.

Retrieved from the Walden Library databases

Carneiro, R., Zeytinoglu, S., Hort, F., & Wilkins, E. (2013). Culture, beauty, and therapeutic alliance. *Journal of Feminist Family Therapy: An International Forum, 25*(2), 80-92.

Carr, A. (1998). Michael White's narrative therapy. *Contemporary family therapy: An International Journal, 20*(4), 485-503.

Castonguay, L. G., Youn, S. J., Xiao, H., & McAleavey, A. A. (2018). The therapeutic relationship: A warm, important, and potentially mutative factor in cognitive-behavioral therapy. In O. Tisby, & H. Wiseman (Eds.), *Developing the therapeutic relationship: Integrating case studies, research, and practice*. (pp. 157-179). American Psychological Association.

Chinonso, L. N., & Barnabas, E. N. (2017). Influence of self-esteem, closeness of relationship and gender on self-disclosure. *Journal of Psychology & Sociological Studies, 1*(1), 186-203.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences*, 2nd edition. Lawrence Erlbaum Associates.

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112*, 155-159.

Collins, N. L., & Miller, L. C. (1994). Self-disclosure and liking: A meta-analytic review *Psychological Bulletin, 116* (3), 457-475.

Cooper, H. (2018). *Reporting quantitative research in psychology: How to meet APA style journal article reporting standards*. American Psychological Association.

Corrigan, P. W., & Rao, D. (2012). On the self-stigma of mental illness: Stages, disclosure, and strategies for change. *Canadian Journal of Psychiatry, 57*, 464 – 469.

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). Sage.

Danzer, G. S. (2019). *Therapist self-disclosure: An evidence-based guide for practitioners*. Routledge.

D'Aniello, C., & Nguyen, H. (2017). Considerations for intentional use of self-disclosure for family therapists. *Journal of Family Psychotherapy, 28*(1), 23-37.

D'Arrigo-Patrick, J., Hoff, C., Knudson-Martin, C., & Tuttle, A. (2017). Navigating critical theory and postmodernism: Social justice and therapist power in family therapy. *Family Process, 56*(3), 574-588.

Dazkir, S., & Read, M. (2012). Furniture forms and their influence on our emotional responses toward interior environments. *Environment and Behavior*, 722-734.

Dean, B. (2010). Therapist self-disclosure: Heterosexual perceptions of sexual minority therapists (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (No UMI No.).

Dienhart, A. (2001). Engaging men in family therapy: Does the gender of the therapist make a difference? *Journal of Family Therapy, 23*(1), 21–45. Retrieved from https://doi.org/10.1111/1467-6427.00167.

Dindia, K., & Allen, M. (1992). Sex differences in self-disclosure: A meta-analysis. *Psychological Bulletin, 112*, 106-124.

DeRubeis, R. J., Webb, C. A., Tang, T. Z., & Beck, A. T. (2010). Cognitive therapy. In K. S. Dobson (Ed.), *Handbook of cognitive behavioral therapies* (3rd ed.) (pp. 277-316). Guilford Press.

Diorinou, M., & Tseliou, E. (2014). Studying circular questioning 'in situ': Discourse analysis of a first systemic family therapy session. *Journal of Marital and Family Therapy, 40*(1), 106-121.

Drescher, J. (2013). Ghosts in the consulting room: A discussion of Anson's "Ghosts in the Dressing Room," Journal *of Gay & Lesbian Mental Health, 17*(1), 112-120.

Edwards, C. E., & Murdock, N. L. (1994). Characteristics of therapist self-disclosure in the counseling process. *Journal of Counseling and Development, 72*, 384-389.

Ellis, A. (1989). Using rational-emotive therapy (RET) as a crisis intervention: A single session with a suicidal client. *Individual Psychology: Journal of Adlerian Theory, Research & Practice, 45*(1/2), 75–81. Retrieved from the EBSCO databases (Accession No. 9102702).

Ehrlich, L. T. (2020). The case of J: Working as a psychoanalyst during the Pandemic. *The International Journal of Psychoanalysis, 101*(4), 791-796.

Farber, B. A. (2006). *Self-disclosure in psychotherapy*. Guilford.

Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, *39*, 175-191.

Fiske, S. T., Gilbert, D. T., & Lindzey, G. (Eds.). (2010). *The handbook of social psychology* (Vol.1, 5th ed.). Wiley.

Fiske, S. T. (2014). *Social beings: Core motives in social psychology.* (3rd ed). Wiley.

Forrest, G. G. (2012). *Self-disclosure in psychotherapy and recovery*. Jason Aronson.

Frankfort-Nachmias, C., & Leon-Guerrero, A. (2015). Social statistics for a diverse society (7th ed.). Sage Publications.

Freud, S. (1963). Recommendations for physicians on the psychoanalytic method of treatment. In S. Freud, *Therapy & technique*. Collier. (Original work published 1912)

Freud, S. (1966/1912). *Recommendations to physicians practicing psychoanalysis.* In J. Strachey (Ed./Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, p. 109-120). Hogart Press.

Gelso, C. J., & Palma, B. (2011). Directions for research on self-disclosure and immediacy: Moderation, mediation, and the inverted U. *Psychotherapy, 48*(4), 342–348.

Gibson, M. F. (2012). Opening up: Therapist's self-disclosure in theory, research, and practice. *Clinical Social Work Journal, 40*(3), 287-296.

Greenberg, J., & Alanson, W. (1995). Self-disclosure: Is it psychoanalytic? *Contemporary Psychoanalysis, 31*(2), 193 – 205. AN 1195-38057-001

Greenberg, L.S., Safran J., & Rice, L. (1989). Experiential therapy: Its relation to cognitive therapy. In: A. Freeman, K. M. Simon, L. E. Beutler, & H. Arkowitz (Eds.) *Comprehensive handbook of cognitive therapy* (pp. 169-170). Springer.

Groth-Marnat, G. (2009). *Handbook of psychological assessment* (5th ed.). John Wiley & Sons, Inc.

Hansen, J. A. (2008). *Therapist self-disclosure: Who and when.* (Doctoral dissertation). Retrieved from ProQuest Dissertations & Theses. (3305818)

Hendrick, S. S. (1988). Counselor self-disclosure. *Journal of Counseling and Development, 66*(9), 419-424.

Henretty, J. R., Currier, J. M., Berman, J. S., & Levitt, H. M. (2014). The impact of counselor self-disclosure on clients: A meta-analytic review of experimental and quasi-experimental research. *Journal of Counseling Psychology, 61*(2), 191-207.

Henretty, J. R., & Levitt, H. M. (2010). The role of therapist self-disclosure in psychotherapy: A qualitative review. *Clinical Psychology Review, 30*(1), 63-77.

Hill, C. E., & Knox, S. (2001). Self-disclosure. *Psychotherapy, 38*, 413- 417.

Hill, C. E., Knox, S., & Pinto-Coelho, K. G. (2018). Therapist self-disclosure and immediacy: A qualitative meta-analysis. *Psychotherapy, 55*(4), 445-460.

Højgaard, A. D., & Laursen, B. S. (2017). What Danish patients want: Gender, profession and age of therapist. *Sexologies: European Journal of Sexology and Sexual Health / Revue, 26*(3), 21-25.

Horsburgh, J., & Ippolito, K. (2018). A skill to be worked at: Using social learning theory to explore the process of learning from role models in clinical settings. *BMC Medical Education 18*(1)**,** 1-8.

Huang, T., Hill, C., & Gelso, C. (2013). Psychotherapy engagers versus non-engagers: Differences in alliance, therapist verbal response modes, and client attachment.

Psychotherapy Research, 23, 568–577. https://doi.org/10.1080/10503307.2013.807378

Hurley, J. R., & Hurley, S. J. (1969). Toward authenticity in measuring self-disclosure. *Journal of Counseling Psychology, 16*(3), 271-274.

Ivey, A. E., Ivey, M. B., & Zalaquett, C. P. (2014*). Intentional interviewing and counseling: Facilitating client development in a multicultural society* (8th ed.). Brooks/Cole.

Jacobs, T. J. (1997). Some reflections on the question of self-disclosure. *Journal of Clinical Psychoanalysis, 6*(2), 161 – 173.

Jacobs, T. J. (1999). On the question of self-disclosure by the analyst: Error or advance in technique? *Psychoanalytic Quarterly, 68*(2), 159 – 183.

Jamieson, S. (2004). Likert scales: How to (ab)use them. *Medical Education, 38*, 1212-1218.

Janis, I. L. (1982). *Groupthink* (2nd ed.). Houghton Mifflin.

Janusz, B., Józefik, B. & Peräkylä, A. (2018). Gender-related issues in couple therapists' internal voices and interactional practices. *Australian & New Zealand Journal of Family Therapy, 39*, 436-449.

Jeske, D., Lippke, S., & Shultz, K. S. (2019). Predicting self-disclosure in recruitment in the context of social media screening. *Employee Responsibilities & Rights Journal, 31*(2), 99-112.

John, L. K., Acquisti, A. & Loewenstein, G. (2011). Strangers on a plane: Context-dependent willingness to share sensitive information. *Journal of Consumer Research, 37* (5), 858-873.

Joinson, A. N. (2001). Knowing me, knowing you: Reciprocal self-disclosure in internet-based surveys. *CyberPsychology & Behavior, 4*(5), 587-591.

Jones, E. E., & Zoppel, C. I. (1982). Impact of client and therapist gender on psychotherapy process and outcome. *Journal of Consulting and Clinical Psychology, 50*(2), 259-272.

Jourard, S. M. (1959). Self-disclosure and other-cathexis. *Journal of Abnormal and Social Psychology, 59(*3), 428 – 431.

Jourard, S. M. (1961). Self-disclosure and grades in nursing college. *Journal of Applied Psychology, 45*, 244-247.

Jourard, S. M. (1969). The effects of experimenter self-disclosure on subjects' behavior. *Current Topics in Clinical and Community Psychology, 1*, 109-149.

Jourard, S. M. (1973). *Self-disclosure: An experimental analysis of the transparent self*. Robert E. Krieger.

Jourard, S. M., & Landsman, M. J. (1960). Cognition, cathexis, and the “dyadic effect” in men’s self-disclosing behavior. *Merrill-Palmer Quarterly, 6*, 178-186.

Jourard, S. M., & Lasakow, P. (1958). Some factors in self-disclosure. *The Journal of Abnormal and Social Psychology, 56*(1), 91-98.

Kazdin, A. E., & Blase, S. L. (2011). Rebooting psychotherapy research and practice to reduce the burden of mental illness. *Perspectives on Psychological Science, 6*(1), 21-27.

Kilborne, B. (2008). Human foibles and psychoanalytic technique: Freud, Ferenczi, and Gizella Palos. *The American Journal of Psychoanalysis, 68*, 1-23.

Kim, M. S., & Kim, S. (2018). Factors influencing willingness to provide personal information for personalized recommendations. *Computers in Human Behavior, 88*, 143-152.

Kivlighan, D. M., Hooley, I. W., Bruno, M. G., Ethington, L. L., Keeton, P. M., & Schreier, B. A. (2018). Examining therapist effects in relation to clients' race-ethnicity and gender: A Intersectionality approach. *Journal of Counseling Psychology, 66*(1), 122-129.

Knapp, S. J., Gottlieb, M. C., & Handelsman, M. M. (2015). Boundary issues. In: *Ethical dilemmas in psychotherapy: Positive approaches to decision making*. (pp. 101-115). American Psychological Association. https://doi.org/10.1037/14670-007

Knox, S., & Hill, C. E. (2003). Therapist self-disclosure: Research-based suggestions for practitioners. *Journal of Clinical Psychology, 59*(5), 529-539.

Kohut, H. (1971). *The analysis of the self*. International Universities Press.

LaPorte, H., Sweifach, J., & Linzer, N. (2010). Sharing the trauma: Guidelines for therapist self-disclosure following a catastrophic event. *Best Practices in Mental Health, 6*(2), 39-56.

Larson, K. E., & Bradshaw, C. P. (2017). Cultural competence and social desirability among practitioners: A systematic review of the literature. *Children and Youth Services Review, 76*, 100-110.

Larson, S. E., & Anderson, M. S. C. (2019). Gender issues when working with men with depression: A novice counsellor's perspective. *Canadian Journal of Counselling and Psychotherapy 53*(3), 232-254.

Laureate Education, Inc. (Executive Producer). (2012). *Week 1: Lobes of the brain* [Interactive multimedia]. Author.

Laureate Education (Producer). (2017). *Introduction to analysis of variance with repeated measures* [Video file]. Author.

Lee, E. (2014). A therapist's self-disclosure and its impact on the therapy process in cross-cultural encounter: Disclosure of personal self, professional self, and/or cultural self? *Families in Society: The Journal of Contemporary Social Services*, *95*(1), 15-23.

Lee, S., & Choi, J. (2017). Enhancing user experience with conversational agent for movie recommendation: Effects of self-disclosure and reciprocity. *Journal of Human Computer Studies, 103*, 95-105.

Levitt, H. M., Minami, T., Greenspan, S. B., Puckett, J. A., Henretty, J. R., Reich, C. M., & Berman, J. S. (2015). How therapist self-disclosure relates to alliance and outcomes: A naturalistic study. *Counseling Psychology Quarterly, 29*(1), 7-28.

Liddon, L., Kingerlee, R., & Barry, J. A. (2018). Gender differences in preferences for psychological treatment, coping strategies, and triggers to help-seeking. *British Journal of Clinical Psychology, 57*, 42-58.

Liu, S. (2021). Center for Research Quality: Quantitative methodology advice. Retrieved from https://academicguides.waldenu.edu/research-center/student-research/quantitative-office-hours

Lucksted A, Drapalski A, Calmes C., Forbes, C., DeForge, B., & Boyd, J. (2011). Ending self-stigma: Pilot evaluation of a new intervention to reduce internalized stigma among people with mental illnesses. *Psychiatric Rehabilitation Journal, 35*(l), 5l-54.

Marks, E. C., Hill, C. E., & Kivlighan, D. M. (2018). Secrets in psychotherapy: For better or worse? *Journal of Counseling Psychology, 66*(1), 70-82.

Mauss, I. B., Levenson, R. W., McCarter, L., Wilhelm, F. H., & Gross, J. J. (2005). The tie that binds? Coherence among emotion experience, behavior, and physiology. *Emotion, 5*(2), 175–190.

Mata, R., Pachur, T., von Helversen, B., Hertwig, R., Rieskamp, J., & Schooler, L. (2012). Ecological rationality: A framework for understanding and aiding the aging decision maker. *Frontiers in Neuroscience, 6*, 19. https://doi.org/10.3389/fnins.2012.00019

Melumad, S., & Meyer, R. (2020). Full disclosure: How smartphones enhance consumer self-disclosure. *Journal of Marketing, 84*(3), 28-45.

Miller, N. E., & Dollard, J. C. (1941). *Social learning and imitation*. Yale University Press.

Miller, E., & McNaught, A. (2016). Exploring decision making around therapist self-disclosure in cognitive behavioural therapy. *Australian Psychologist, 53*, 33-39.

Muntigl, P., & Horvath, A.O. (2016). A conversation analytic study of building and repairing the alliance in family therapy. *Journal of Family Therapy, 38*, 102–119.

Murphy, E., Mansell, W., Craven, S. & McEvoy, P. (2016). Approach-avoidance attitudes associated with initial therapy appointment attendance: A prospective study. *Behavioural and Cognitive Psychotherapy, 44*(1), 118-122.

National Academies of Sciences, Engineering, and Medicine. (2016). *Ending discrimination against people with mental and substance use disorders: The evidence for stigma change*. The National Academies Press. https://doi.org/10.17226/23442

NCSPP. (2007). Competency Developmental Achievement Levels (DALs) of the National Council of Schools and Programs in Professional Psychology (NCSPP). Retrieved from https://www.ncspp.info/DALof%20NCSPP%209-21-07.pdf

Neisser, U. (1967). *Cognitive psychology*. Appleton-Century-Crofts.

Norcross, J. C. (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. Oxford University Press.

Olson, M. H., & Hergenhahn, B. R. (2017). *An introduction to theories of learning* (9th ed.). Pearson.

Paine, A. L., McCarthy-Veach, P., MacFarlane, I. M., Thomas, B., Ahrens, M., & LeRoy, B. S. (2010). "What would you do if you were me?" Effects of counselor self-disclosure versus non-disclosure in a hypothetical genetic counseling session. *Journal of Genetic Counseling, 19*(6), 570-584.

Panyard, C. M. (1971). Method to improve the reliability of the Jourard Self-Disclosure Questionnaire. *Journal of Counseling Psychology, 18*(6), 606.

Peng, C. Y., J., Long, H., & Abaci, S. (2012). Power analysis software for educational researchers. *Journal of Experimental Education, 80*(2), 113-136.

Phiri, P., Rathod, S., Gobbi, M., Carr, H., & Kingdon, D. (2019). Culture and therapist self-disclosure. *The Cognitive Behaviour Therapist, 12*(25), 1-20.

Pinto-Coelho, K. G., Hill, C. E., Kearney, M. S., Sarno, E. L., Sauber, E. S.; Baker, S. M., Brady, J., Ireland, G. W., Hoffman, M. A., Spangler, P. T., & Thompson, B. J. (2018). When in doubt, sit quietly: A qualitative investigation of experienced therapists' perceptions of self-disclosure. *Journal of Counseling Psychology, 65*(4), 440-452.

Pinto-Coelho, K. G., Hill, C. E., & Kivlighan, D. M. Jr. (2016). Therapist self-disclosure in psychodynamic psychotherapy: A mixed methods investigation. *Counselling Psychology Quarterly, 29*(1), 29-52.

Priebe, S., Omer, S., Giacco, D., & Slade, M. (2014). Resource-oriented therapeutic models in psychiatry: Conceptual review. *The British Journal of Psychiatry, 204*(4), 256-261.

Radulescu, A., Daniel, R., & Niv, Y. (2016). The effects of aging on the interaction between reinforcement learning and attention. *Psychology and Aging, 31*(7), 747-757.

Ramshaw, A. (2021). What is Survey Monkey? https://www.genroe.com/blog/what-is-surveymonkey/7979

Raphael, K. G., & Dohrenwend, B. P. (1987). Self-disclosure and mental health: A problem of confounded measurement. *Journal of Abnormal Psychology, 96*(3), 214-217.

Reavley, N. J., & Jorm, A. F. (2014). Willingness to disclose a mental disorder and knowledge of disorders in others: Changes in Australia over 16 years Australian and New Zealand. *Journal of Psychiatry, 48*(2), 162-168.

Ringel, S. (2002). To disclose or not to disclose: Political conflicts in the countertransference. *Smith Studies in Social Work, 72*(3), 347-358.

Roberts, C. M. (2010). *The dissertation journey: A practical and comprehensive guide to planning, writing, and defending your dissertation* (2nd ed.). Corwin.

Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implications, and theory*. Houghton Mifflin.

Rogers, C. (1961). *On becoming a person*. Houghton Mifflin.

Seidman, A. J., Lannin, D. G., Heath, P. J., & Vogel, D. L. (2019). Setting the Stage: The effect of affirming personal values before psychotherapy intake screenings on perceptions of self-stigma and self-disclosure. *Stigma and Health, 4*(3), 256-259.

Shapero, A. (1968). Relationship between self-concept and self-disclosure. *Dissertation Abstracts, 29*, 1180-1181.

Sheldon, P. (2013). Examining gender differences in self-disclosure on Facebook versus face-to-face. *The Journal of Social Media in Society, 2*(1), 88-105.

Snell, W. E., Jr., Miller, R. S., Belk, S. S., Garcia-Falconi, R., Hernandez-Sanchez, J. E. (1989). Men's and women's emotional disclosures: The impact of disclosure recipient, culture, and the masculine role. *Sex Roles: A Journal of Research, 21*(7-8), 467-486.

Snell, W. E., Jr., Miller, R. S., & Belk, S. S. (2013). The emotional self-disclosure scale (ESDS). Measurement Instrument Database for the Social Science. Retrieved from https://www.midss.ie

Snell, W. E., Jr., Miller, R. S., & Belk, S. S. (1988). Development of the emotional self disclosure scale. *Sex Roles: A Journal of Research 18*(1-2), 59-73. Retrieved from https://doi.org/10.1007/BF00288017

Staczan, P., Schmuecker, R., Koehler, M., Berglar, J., Crameri, A., von Wyl, A., Koemeda-Lutz, M., Schulthess, P., & Tschuschke, V. (2017). Effects of sex and gender in ten types of psychotherapy. *Psychotherapy Research, 27*(1), 74-88.

Stokoe, E. H. (2004). Gender and discourse, gender and categorization: Current developments in language and gender research. *Qualitative Research in Psychology, 1*(2), 107-109.

Sturges, J. (2012). Use of therapist self-disclosure and self-involving statements. *The Behavior Therapist, 35*(5), 90-93.

Sweet, H. (2006). Finding the person behind the persona: Engaging men as a female therapist. In M. Englar-Carlson & M. A. Stevens (Eds.), *In the room with men: A casebook of therapeutic change* (p. 69–90). American Psychological Association. https://doi.org/10.1037/11411-004

Tabol, C., & Walker, G. (2008). The practice of psychotherapy: Application. In M. Ballou, M. Hill, & C. West (Eds.), *Feminist therapy theory and practice: A contemporary perspective* (pp. 87-108). Springer.

Taddicken, M. (2014). The 'privacy paradox' in the social web: The impact of privacy concerns, individual characteristics, and the perceived social relevance on different forms of self-disclosure. *Journal of Compute-Mediated Communication, 19*, 248–273.

Taniguchi, E., & Glowacki, E. M. (2021, May 6). Reactions to depression disclosure on Facebook: Evaluating the effects of self-presentation style and peer comments. *Stigma and Health.* Retrieved October 16, 2021, from https://doi.org/10.1037/sah0000309

Thomas, M. (2008). Shades of gray: Lesbian therapist explore the complexities of self-disclosure to heterosexual clients (Doctoral dissertation). Retrieved from Smith College Theses, Dissertations, and Projects.

Tolman, E. C. (1948). Cognitive maps in rats and men. *Psychological Review, 55*(4), 189–208.

Tsai, M., Plummer, M., Kanter, J., Newring, R., & Kohlenberg, R. (2010). Therapist grief and functional analytic psychotherapy: Strategic self-disclosure of personal loss. *Journal of Contemporary Psychotherapy, 40*(1), 1-10.

Tseliou, E., & Borsca, M. (2018). Discursive methodologies for couple and family therapy research: Editorial to special section. *Journal of Marital and Family Therapy, 44*, 375–385 (in print).

Trump, C. E., Ayres, K. M., Quinland, K. K., & Zabala, K. A. (2019, October 10). Differential reinforcement without extinction: A review of the literature. *Behavior Analysis: Research and Practice*. Advance online publication. https://doi.org/10.1037/bar0000169

U. S. Census Bureau. (2021). COVID-19, Declining birth rates and international migration resulted in historically small population gains. https://www.usa.gov/federal-agencies/u-s-census-bureau

Vandenberghe, L., & Silva Silvestre, R. (2014). Therapists' positive emotions in-session: Whey they happen and what they are good for. *Counseling and Psychotherapy Research, 14*(2), 119-27.

Vogt, W. P., Gardner, D. C., & Haeffele, L. M. (2012). *When to use what research design*. The Guilford Press.

Wachtel, P. L. (2008). *Rational theory and the practice of psychotherapy*. The Guilford Press.

Wagner. W. E. (2017). *Using IBM SPSS statistics for research methods and social science statistics*. SAGE Publications, Inc.

Walden University (Producer). (2010). Research approaches and theoretical frameworks. [Video]. Retrieved from https://academicguides.waldenu.edu/researchcenter/resources/planning

Walden University. (2015). Social change. Retrieved from https://www.waldenu.edu/about/social-change

Walen, S., DiGiuseppe, R., & Dryden, W. (1992). *A practitioner's guide to rational-emotive therapy*. Oxford University Press.

Warner, R. M. (2013). *Applied statistics: From bivariate through multivariate techniques* (2nd ed.). SAGE Publications.

Watkins, C. E. (1990). The effects of counselor self-disclosure: A research review. *The Counseling Psychologist, 18*(3)*,* 477 – 500.

Watkins, P. (2010). *Person-centered therapy: 100 Key points*. New York: Routledge.

Wester, S. R., McDonough, T. A., White, M., Vogel, D. L., & Taylor, L. (2010). Using gender role conflict theory in counseling male-to-female transgender individuals. *Journal of Counseling & Development, 88*(2), 214–219. https://doi.org/10.1002/j.1556-6678.2010.tb00012.x

Whitaker, C. A. (1973). My philosophy of psychotherapy. *Journal of Contemporary Psychotherapy, 6*(1), 49-52.

Whitaker, C. A. (1976). Hindrance of theory in clinical work. In P. J. Guerin Jr (Ed.), *Family therapy, theory, and practice* (pp. 154-164). Garden Press.

White, M. (2009). Narrative practice and conflict dissolution in couples therapy. *Clinical Social Work Journal, 37*(3), 200-213.

Willyard, C. (2011). Men: A growing minority? Women earning doctoral degrees in psychology outnumber men three to one. What does this mean for the future of the field? *American Psychological Association, 1*, 40.

Wright, K. B. (2005). Researching inter-based populations: Advantages and disadvantages of online survey research, online questionnaire authorizing software packages, and web survey services. *Journal of Computer-Mediated Communication, 10*(3), article 11. https://jcmc.indiana.edu/voll0/issue3/wright.html

Ziv-Beiman, S., & Shahar, G. (2016). Therapeutic self-disclosure in integrative psychotherapy: When is this a clinical error? *Psychotherapy, 53*(3), 273-277).

Ziv-Beiman, S., Keinan, G., Livneh, E., Malone, P. S., & Shahar, G. (2018). Immediate therapist self-disclosure bolsters the effect of brief integrative psychotherapy on psychiatric symptoms and the perceptions of therapists: A randomized clinical trial. *Psychotherapy Research, 27*(5), 558-570.

Zur, O. (2010). Self-disclosure. In I. Weiner & W. Craighead (Eds.), *The Corsin encyclopedia of psychology* (4th ed., pp. 1532-4). John Wiley & Sons.

Appendix A: Demographic Information

Please complete this demographic section of the survey by carefully and accurately answering each question. None of your personal information will be revealed in the study results.

1. What is your gender?
    a. Male
    b. Female
    c. Non-binary
2. What is the gender of your therapist?
    a. Male
    b. Female
    c. Non-binary
3. What is your age?
    a. 18 to 24
    b. 25 to 34
    c. 35 to 44
    d. 45 to 54
    e. 55 to 60
4. What is your annual income?
    a. $25,000 to $35,000
    b. $36,000 to $45,000

c. $46,000 to $55,000

d. $56,000 to $65,000

e. $66,000 to $75,000

f. Over $75,000

5. What is your race?

    a. Caucasian

    b. Black

    c. Hispanic

    d. Asian

    e. Multiracial

Appendix B: Counselor Disclosure Scale

Created by Hendrick (1988, 1990)

Counselor Disclosure Scale

Instructions: Imagine that you are a client going to see a counselor. How much would you like to know about the counselor-about his or her background, attitudes, interests, etc.? On the following questionnaire, indicate how much you would like or dislike hearing about particular counselor' related topics.

Item	Always	Often	Sometimes	Rarely	Never
1. The counselor's feelings of anxiety					
2. The counselor's feelings of depression					
3. The counselor's feelings of happiness					
4. The counselor's fears					
5. The counselor's suicidal thoughts					
6. The counselor's feeling about his/her physical appearance					
7. The counselor's feelings about his/her personality					
8. The counselor's relationship with his/her spouse					
9. The counselor's relationship with his/her children					
10. The counselor's relationship with his/her parents					
11. The counselor's relationship with his/her close friends					
12. The counselor's attitudes toward sex					
13. The counselor's personal sexual practices					
14. The counselor's sexual orientation					
15. The counselor's personal successes					
16. The counselor's personal failures					
17. The counselor's professional successes					
18. The counselor's professional failures					

19. The counselor's religious beliefs					
20. The counselor's political views					
21. The counselor's professional degree					
22. The counselor's training and professional experience					
23. The counselor's theoretical approach to counseling					
24. The "diagnosis" that the counselor has given me					
25. How the counselor has coped with problems he/she has had					
26. The counselor's feelings of anger					
27. Whether the counselor is attracted to me					
28. Whether the counselor has ever been physically or sexually abused					
29. Information about the counselor's family background					
30. Information about the counselor's health					
31. The counselor's personal tastes in art, music, books, and movies					
32. Whether the counselor likes his/her work					

Appendix C: Emotional Self-Disclosure Scale

Created by Snell, Miller, & Belk (1988, 2013)

Instructions: Listed below are 40 topics concerned with the types of feelings and emotions that people experience at one time or another in their life. This survey is concerned with the extent to which you have discussed these feelings and emotions with your counselor. Before each item you will notice a single column. For this column you are to indicate how often you have discussed each specific topic with your counselor. To respond, use the following scale to indicate which letter (A, B, C, D, or E) corresponds to your response:

A = I have not discussed this topic with my counselor;
B = I have slightly discussed this topic with my counselor;
C = I have moderately discussed this topic with my counselor;
D = I have almost fully discussed this topic with my counselor;
E = I have fully discussed this topic with my counselor.

Please be sure to answer each question, even if you are not sure.

1. ____ Times when you felt depressed.
2. ____ Times when you felt happy.
3. ____ Times when you felt jealous.
4. ____ Times when you felt anxious.
5. ____ Times when you felt angry.
6. ____ Times when you felt calm.
7. ____ Times when you felt apathetic.
8. ____ Times when you felt afraid.
9. ____ Times when you felt discouraged.
10. ____ Times when you felt cheerful.
11. ____ Times when you felt possessive.
12. ____ Times when you felt troubled.
13. ____ Times when you felt infuriated.
14. ____ Times when you felt quiet.
15. ____ Times when you felt indifferent.
16. ____ Times when you felt fearful.
17. ____ Times when you felt pessimistic.
18. ____ Times when you felt joyous.
19. ____ Times when you felt envious.
20. ____ Times when you felt worried.
21. ____ Times when you felt irritated.
22. ____ Times when you felt serene.
23. ____ Times when you felt numb.

24. ____ Times when you felt frightened.
25. ____ Times when you felt sad.
26. ____ Times when you felt delighted.
27. ____ Times when you felt suspicious.
28. ____ Times when you felt uneasy.
29. ____ Times when you felt hostile.
30. ____ Times when you felt tranquil.
31. ____ Times when you felt unfeeling.
32. ____ Times when you felt scared.
33. ____ Times when you felt unhappy.
34. ____ Times when you felt pleased.
35. ____ Times when you felt resentful.
36. ____ Times when you felt flustered.
37. ____ Times when you felt enraged.
38. ____ Times when you felt relaxed.
39. ____ Times when you felt detached.
40. ____ Times when you felt alarmed.

Appendix D: Permission to Use the Counselor Disclosure Scale

From: Hendrick, S <S.Hendrick@ttu.edu>
Sent: Sunday, December 12, 2021 4:27 PM
To: Robert Chorney <robert.chorney@waldenu.edu>
Subject: RE: Requesting Permission

Robert,

You have my full permission to use the Counselor Disclosure Scale in your research.
Best wishes.

Susan Hendrick

Susan S. Hendrick, PhD
Paul Whitfield Horn Professor of Psychological Sciences, Emeritus
Department of Psychological Sciences
Texas Tech University

Appendix E: Permission to Use the Emotional Self-Disclosure Scale

Automatic reply: ESDS

External

Inbox

m

MIDSS via **nuigalwayie.onmicrosoft.com** **3/24/22** 9:44 AM (4 minutes ago)

to me

To Whom It May Concern,

Below are the answers to the two question I most commonly received emails about. If you have a different question, I will give you an individual response in due course.

Can I use/adapt a specific instrument listed on MIDSS?

You are free to use and adapt any instruments on MIDSS under the Creative Commons attribution non-commercial 3.0 licence. What this means is that you can use, share, translate, or adapt the instrument. However, you must cite the original creator of the instrument, and the instrument cannot be used for commercial purposes without the consent of the original author.

How do I use/score a specific instrument on MIDSS?

I am not the author of the instrument, so cannot provide any advice on the use or scoring of the data collected using the instrument. My only advice is to read the key references listed with the instrument and/or contact the author of the instrument directly (their information should be on the key reference listed with the instrument). That is the best I can do I am afraid.

Many thanks,

Paul O'Connor
MIDSS manager