

THE EFFECTS OF SELF-DISCLOSURE AND THERAPIST/CLIENT-GENDER DYADS ON
THE PERCEIVED WORKING ALLIANCE

by

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B.A., University of Nebraska at Kearney, 1988
M.S., Creighton University, 1995

AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

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Department of Special Education, Counseling, and Student Affairs
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Abstract

This study examined the effects of types of therapist disclosure and their interaction with various combinations of observer, therapist, and client gender-dyads on observer ratings of the working alliance. Participants were 357 undergraduate students (60.2% women) from two Midwestern universities who were randomly assigned to one of 12 conditions. Each condition required students to read one of 12 printed scenarios differentiated by all possible combinations of three types of therapist self-disclosure (similar, dissimilar, no disclosure), two levels of therapist gender, and two levels of client gender. Students rated the scenarios on the perceived working alliance between the therapist and the client, using the 36-item *Working Alliance Inventory-Observer* (WAI-O). A 2 (student sex) x 2 (therapist sex) x 2 (client sex) x 3 (disclosure type) ANOVA revealed no significant effects on the WAI-O total scale score. In addition, no main effects or interactions were found on WAI-O total scale when male and female student scores were pooled. A 2 x 2 x 2 x 3 MANOVA performed on the WAI-O subscales indicated female observers perceived a stronger client-therapist bond for similar than dissimilar disclosures with male clients. Female observers rated male clients with a stronger bond than female clients, but only in the similar disclosure condition. A main effect was also found for observer sex on the Task and Bond subscales. Although this study did not find gender of the observer, type of therapist disclosure, and the gender of the therapist and their client to influence overall working alliance ratings, results suggest that these factors have an impact on female observer ratings of the bond and task agreement between the therapist and their client. Specifically, two findings emerged: (a) women, not men, observed a stronger bond for male client recipients of similar versus dissimilar disclosure; (b) women, not men observed a stronger

bond for male client versus female recipients of a therapist's similar disclosure. Results are discussed in terms of disclosure and gender research.

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Table of Contents

List of Figures	xi
List of Tables	xii
Dedication	xiv
CHAPTER ONE	15
Introduction.....	15
Self-Disclosure and Abuse of Power	16
The Beginning of Research on Self-Disclosure.....	17
Limitations of Previous Research	18
Purpose of Study	19
Research Questions & Subquestions	20
Research Questions	20
Subquestions	21
Definitions	21
CHAPTER TWO	23
Review of the Literature	23
Self-Disclosure Defined.....	23
Early Philosophical Perspectives	24
Evolving Debate and Contemporary Perspectives on Therapist Disclosure	26
Self-Disclosure in Feminist Therapy	28
Self-Disclosure Issues.....	29
Therapist Frequencies of Self-Disclosure.....	30
Self-Disclosure Rationale	32
Self-Disclosure Contraindications	34
Self-Disclosure Research Findings.....	35
Benefits	35
Negative Effects.....	36
Paucity of Research.....	37
Self-Disclosure Valence: Similar and Dissimilar Forms	37

Similar and Dissimilar Self-Disclosure Defined.....	37
Similar and Dissimilar Self-Disclosure Research Findings.....	38
Self-Disclosure Research Recommendations	43
Gender and the Treatment Dyad.....	46
Male Client/Male Therapist Treatment Dyad.....	46
Female Client/Female Therapist Treatment Dyad.....	47
Male Client/Female Therapist Treatment Dyad.....	49
Female Client/Male Therapist Treatment Dyad.....	51
Summary of Treatment Dyads.....	51
Working Alliance Defined.....	52
The Working Alliance and Outcome	55
Working Alliance and Gender	56
The Working Alliance and Self-Disclosure.....	58
Summary.....	60
Research Questions & Hypotheses	61
CHAPTER THREE	64
Method.....	64
Participants.....	64
Materials	65
Therapy Transcripts	65
Instrument.....	67
<i>Procedure</i>	71
Hypotheses.....	74
CHAPTER FOUR.....	76
Results.....	76
CHAPTER FIVE	90
Discussion.....	90
References.....	115
Appendix A.....	129
Appendix B.....	134
Appendix C.....	139

Appendix D.....	144
Appendix E.....	149
Appendix F.....	154
Appendix G.....	159
Appendix H.....	164
Appendix I.....	169
Appendix J.....	174
Appendix K.....	179
Appendix L.....	184
Appendix M.....	189
Appendix N.....	190
Appendix O.....	192
Appendix P.....	193
Appendix Q.....	194

List of Figures

Figure 1	Research Design	72
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List of Tables

Table 1	Frequencies and Percentages for Demographic Characteristics of Participants.....	65
Table 2	WAI-O Means and Standard Deviations by Therapist Sex, Client Sex, and Disclosure Type (Male Observers)	77
Table 3	WAI-O Means and Standard Deviations by Therapist Sex, Client Sex, and Disclosure Type (Female Observers)	77
Table 4	Analysis of Variance Results for Main Effects and Interaction Effects of Data Collection Group, Sex of Therapist, Sex of Client, and Type of Disclosure on Male Observer Ratings of the Working Alliance Inventory (WAI-O)	79
Table 5	Analysis of Variance Results for Main Effects and Interaction Effects of Data Collection Group, Sex of Therapist, Sex of Client, and Type of Disclosure on Female Participant Ratings of the Working Alliance Inventory (WAI-O)	80
Table 6	WAI-O Bond, Task, and Goal Component Means and Standard Deviations by Sex of Therapist, Sex of Client, and Type of Disclosure – Male Observers	82
Table 7	Multivariate and Univariate Analyses of Variance for Working Alliance Scales (WAI-O) – Male Observers	84
Table 8	WAI-O Bond, Task, and Goal Component Means & Standard Deviations for Factors of Observer Sex, Sex of Therapist, Sex of Client, and Type of Disclosure – Female Observers	85
Table 9	Multivariate and Univariate Analyses of Variance for Working Alliance Subscales (WAI-O) – Female Observers.....	86
Table 10	Means and Standard Deviations for Client Sex by Disclosure for Female Observers ..	88

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Dedication

This dissertation is dedicated to my lovely wife Rebecca. I am thankful for her and her unending support.

CHAPTER ONE

Introduction

There is much speculation and difference of opinion among therapists as to the impact of therapist self-disclosure upon the client and the therapeutic relationship (Waska, 1999). Simone, McCarthy, and Skay (1998) reported therapist self-disclosure is a conscious and intentional technique where therapists share personal information about themselves to their clients. Although much has been written about therapist self-disclosure, and several authors have investigated client responses to therapist self-disclosure, many unanswered questions still remain (Dailey, 2004; Myers, 2004; Simi & Mahalik, 1997; Watkins, 1990).

One area in question concerns the impact of therapist utilization of similar and dissimilar forms of self-disclosure upon the working alliance. A similar self-disclosure refers to a therapist's disclosure of an experience which is congruent with a disclosure made by the client, whereas a dissimilar self-disclosure refers to a therapist's disclosure of an experience which is incongruent with a disclosure made by the client (Murphy & Strong, 1973). The effects of these forms of self-disclosure are of particular interest in this study, because no one has examined the comparative effects of a therapist's utilization of similar and dissimilar forms of disclosure upon the working alliance. Horvath and Bedi (2002) described the working alliance as therapist and client ratings of agreement on the therapeutic goals of therapy, consensus with the tasks of therapy, as well as the bond between both the therapist and the client.

Additionally, this study examines whether therapist/client dyads (i.e. male therapist/male client; female therapist/female client; male therapist/female client; female therapist/male client) interact with self-disclosure type in their effects on the working alliance. The 4th edition of Webster's New World College Dictionary (2002) defines a *dyad* as: "two persons in a continuing relationship involving interaction" (p. 444). To accomplish this, college student observers were each randomly assigned to 1 of 12 combinations of disclosure type by therapist/client-gender dyads. Participants (blocked by sex) read one script (similar vs. dissimilar vs. no disclosures) of a hypothetical counseling session between a client (male vs. female) and a therapist (male vs. female) (see Figure 1).

Self-Disclosure and Abuse of Power

Self-disclosure with its various forms, applications, purposes, merits, and shortcomings has been associated with the abuse of power in psychotherapy and has been a source of critical concern since the inception of the "talking cure," also known as psychoanalysis, the first modern form of psychotherapy (Chesler, 1972; Gannon, 1982). Such examples have included the therapist's revelation of personal fantasies, dreams, and sexual or financial information, which might burden the patient and detract from the therapeutic process (Gutheil & Gabbard, 1993). Moreover, sexual misconduct, a documented outcome of self-disclosure, has been and continues to remain a reason of litigation against therapists (Gutheil & Gabbard, 1993; Pope, Tabachnick & Keith-Spiegel, 1987).

The American Psychological Association (APA, 2002) Ethical Principles of Psychologists and Code of Conduct, and the American Counseling Association (ACA,

2005) Code of Ethics and Standards of Practice outline the appropriate and ethical protocol to be included in all client/therapist interactions. In particular, they direct psychologists and counselors to “avoid harm” (ACA, 2005, p. 4; APA, 2002, p. 1062) and avoid “exploitive relationships” (ACA, 2005, p. 10; APA, 2002, p. 1062). Moreover, they require providers to discuss with their clients the elements of informed consent and the recommended course of therapy determined by each client’s individual and specific presenting problems (ACA, 2005; APA, 2002). Unfortunately, neither of these codes and guidelines mentions “therapist self-disclosure,” and neither offers recommendations for avoiding therapist exploitation of the client/therapist relationship (e.g., monitoring the power dynamics of the client/therapist relationship) (ACA, 2005; APA, 2002). However, self-disclosure can be a vehicle to equalize, as much as possible, the power differential between therapists and clients (Simi & Mahalik, 1997), as some have characterized traditional therapy relationships as not unlike unhealthy marital relationships where one party holds the power over the other (Chesler, 1972; Gannon, 1982).

The Beginning of Research on Self-Disclosure

From the early 1950’s through the 1970’s, Sidney Jourard (1971), a humanist psychologist, conducted a considerable amount of research on the topic of self-disclosure to learn more about its relationship with power abuse. Jourard’s research revealed the value of self-disclosure as a critical precursor to intimacy in all relationships. One outcome of Jourard’s work was that a sender’s disclosure of information expresses to the listener a degree of the sender’s vulnerability. This vulnerability is contained in the discloser’s attempt to relate to the listener in a genuine and authentic manner. Such

disclosure facilitates increased sharing within dyads and groups and has the potential to lead to enhanced levels of intimacy for all individuals involved (Jourard, 1971).

Those involved in the academic preparation of therapists and practitioners have often recommended against self-disclosure (Freud, 1912/1959; Gabbard & Nadelson, 1995; Gutheil & Gabbard, 1998; Walker & Clark, 1999). Although many practitioners suggest some disclosure may improve the client/therapist relationship, they hasten to add excessive disclosure because this may lead to serious boundary violations such as sexual involvement (Gabbard & Nadelson, 1995; Gutheil & Gabbard, 1993; 1998; Walker & Clark, 1999). Even if a therapist's self-disclosure does not lead to extreme boundary infractions, such as sexual involvement, some still believe therapist disclosure misuses the patient to satisfy the therapist's personal needs for comfort and sympathy (Gabbard & Nadelson, 1995).

Several studies have investigated various aspects of self-disclosure to examine how it is defined (Pizer, 1995; Simone et al., 1998; Simi & Mahalik, 1997), evaluate which types of self-disclosure are viewed most effective (Giannandrea & Murphy, 1973), and address how the therapist's self-disclosure can impact the perceptions of the client (Murphy, 1973; Strong & Schmidt, 1970). These studies have shown that self-disclosure can lead to numerous positive outcomes, such as increased levels of trust (Myers, 2004); increased levels of client confidence towards the therapist (Cash & Salzbach, 1978); increased levels of the discloser's perceived credibility, empathy, and regard (Hoffman-Graff, 1977); all of which are crucial to the therapy relationship and may influence the therapeutic outcome in a positive or negative manner (Hendrik, 1987).

Limitations of Previous Research

One research limitation of the following studies (Daher & Bannikiotes, 1976; Giannandrea & Murphy, 1973; Mann & Murphy, 1975; Peca-Baker & Friedlander, 1989) is that they have only investigated the influence of one individual's self-disclosure (male or female) upon another's (male or female). Moreover, these studies have utilized disproportionate numbers of female subjects (Cash & Salzbach, 1978; Mann & Murphy, 1975; Peca-Baker & Friedlander, 1987; Peca-Baker & Friedlander, 1989). As a result, the ability to understand gender differences and how they might inform the therapeutic practice of self-disclosure has not been fully realized (Dailey, 2004). Specifically, there is a need to study the effects of client and therapist gender traits and how they influence therapist-client sex pairing in the context of therapist self-disclosure (Sipps & Janeczek, 1986). Consequently, several researchers have recommended research that examines the interaction between therapist/client gender dyads and self-disclosure type (Dailey, 2004; Peca-Baker & Friedlander, 1987; Sipps & Janeczek, 1986; Watkins, 1990).

The preceding brief historical summary clearly establishes the need to examine self-disclosure in the context of both genders, explored via observer-gender comparisons of multiple gender therapy dyads (i.e., male therapist/female client; female therapist/male client; female therapist/female client; and male therapist/male client). Few researchers have investigated the phenomenon of self-disclosure and its impact on the working alliance. However, for those who have explored this phenomenon, they have only investigated the impact of self-disclosure on pre-established working alliances (Dailey, 2004; Myers, 2004). Consequently, the effect of therapist self-disclosure on the working alliance has not specifically been the focus of rigorous investigation.

Purpose of Study

This study focused on the effects of therapist self-disclosure on the working alliance. Several studies have investigated similar versus dissimilar types of self-disclosure and their influences on various therapy outcomes (Giannandrea & Murphy, 1973; Mann & Murphy, 1975; Murphy & Strong, 1973; Nyman & Daugherty, 2001; Peca-Baker & Friedlander, 1989). However, the specific differences between these types of disclosures and their effects on the working alliance are still unknown. Currently, only two studies were found which investigated the relationship between self-disclosure and the working alliance (Dailey, 2004; Myers, 2004). Although these studies examined how self-disclosure affects pre-established working alliances, they did not assess the direct effects of self-disclosure on the working alliance (Dailey, 2004; Myers, 2004). Consequently, the current study investigated these types of self-disclosure (similar vs. dissimilar vs. no disclosure) and their influences on observer perceptions of the provider as an effective helper. In addition, because no one has examined the therapist's utilization of similar and dissimilar self-disclosure in the context of multiple-gendered therapy dyads, this study also examined these influences. Working alliance ratings were used to measure self-disclosure type and gender manipulations of the therapy dynamics and to answer the research questions and subquestions presented below.

Research Questions & Subquestions

Research Questions

1. Are there differences in observer ratings of the working alliance based on the type of therapist disclosure?

2. Are there differences in observer ratings of the working alliance based on the three-way interaction of sex of the observer by sex of the therapist by sex of the client/client gender dyad?
3. Are there differences in observer ratings of the working alliance based on the interaction of observer gender and type of disclosure?

Subquestions

1. How does type of therapist disclosure affect the observer's perceptions of the working alliance?
2. How do sex of the therapist and client affect the observer's perceptions of the working alliance?
3. How do type of therapist disclosure and the sex of the therapist and client affect the observer's perceptions of the working alliance?

Definitions

Self-disclosure refers to the therapist's utilization of statements that reveal something personal about him or herself (Hill & Knox, 2002). For example, a therapist might reveal at the advent of their client's verbalizations of struggles with alcoholism that they too have struggled with alcoholism. A number of types of self-disclosure exist. The above example illustrates a *similar disclosure*, congruence between a therapist's and a client's experience, whereas a disclosure which is incongruent between a therapist and a client is a *dissimilar disclosure* (Murphy & Strong, 1973). Self-disclosure is considered a fundamental aspect for the development of a healthy relationship (Jourard, 1971).

Working alliance refers to three quintessential elements of the therapeutic alliance proposed by Bordin (1976): presence of a therapeutic bond, therapist-client agreement on

the tasks of therapy, and therapist-client agreement on the goals of therapy. According to Horvath and Bedi (2002), the therapeutic bond includes such elements such as mutual trust, liking, respect, and caring between therapist and client. Task and goal elements encompass a more cognitive element of the therapeutic relationship, such as a consensus and commitment to the goals of therapy and the means by which these goals can be reached (Horvath & Bedi, 2002).

Transference refers to the client's display of internal conflicts in the therapeutic relationship (Kramer, 2000). For example, it might be the personal information that a client has conveyed to his or her therapist about depression or relationship problems. *Countertransference* is defined as therapists' reactions to clients that are rooted in therapists' unresolved intrapsychic conflicts (Gelso & Carter, 1985) or therapist's personal feelings which could contraindicate the therapy process (Mathews, 1988).

There is no standard definition of *feminist therapy* (Rader, 2004). Feminist therapy for the purpose of this study refers to a theoretical orientation rather than a defined collection of procedures or therapeutic models (Rader, 2004). Therapists of a feminist therapy orientation frequently endorse therapist disclosure (Enns, 1997), whereas therapists of a psychoanalytic viewpoint commonly avoid therapist disclosure, due to the encouragement that they maintain neutrality (Nilsson, Strassberg, & Bannon, 1979).

CHAPTER TWO

Review of the Literature

Self-Disclosure Defined

Self-disclosure has encompassed a number of definitions (Pizer, 1995; Reexamination of Therapist Self-Disclosure, 2001; Shadley, 2000; Simi & Mahalik, 1997; Simone et al., 1998). Simone et al. (1998) described self-disclosure as a conscious intentional technique where clinicians shared personal information about their lives outside of the counseling relationship. However, in an article entitled, “Reexamination of Therapist Self-Disclosure” (2001), self-disclosure was expanded to include any behavior or verbalization that revealed any personal information about the therapist to their client. Self-disclosure has also been referred to as a therapist’s statements, including past history or personal experiences (Simi & Mahalik, 1997). Simi and Mahalik (1997), however, excluded the nonverbal aspects of communication from their definition, relegating self-disclosure to only include the verbal aspects of communication.

Pizer (1995) conceptualized self-disclosure to exist in one of three types: inescapable, inadvertent, and deliberate. An *inescapable self-disclosure* was described as therapist elements found to be impossible to conceal from one’s clientele (e.g., therapist pregnancy), whereas an *inadvertent self-disclosure* was said to involve instances in which the therapist unknowingly conveyed thoughts and feelings through such avenues as body language, tone of voice, or manner of emotional expression (Pizer, 1995). *Deliberate disclosures*, the final type, were noted to include those instances in which the therapist deliberately shared personal information about themselves to their clientele (Pizer, 1995).

Shadley (2000) conceptualized self-disclosure as a continuum of styles: (a) intimate interaction; (b) reactive response; (c) controlled response; and (d) reflective feedback. *Intimate interactions* are instances where a therapist opens up through verbal and nonverbal expressions of the therapy's therapeutic responses, including references to present or past personal issues (e.g., therapist pregnancy). *Reactive response* includes the therapist's expression of both verbal and non-verbal responses (Shadley, 2000); often involving the revelation of an emotional connectedness within the therapeutic relationship (e.g., therapists crying at something the client had said). However, Shadley (2000) argued that disclosures of this category did not include a therapist's personal experiences outside of the clinical setting. *Controlled response* includes situations in which the therapist maintains a slight distance with the client, including disclosures only of past experiences, anecdotes, nonverbalized feelings, and literary parallels (Shadley, 2000). Moreover, these disclosures only involve situations a therapist considers most valuable to reveal. Reflective feedback, the final style, was reported by Shadley (2000) to be one of the most standard forms taught in classes, referring to those instances in which a therapist would either offer up impressions of a client's issues, or ask questions to reveal a point of view. Furthermore, in this style a therapist seldom shares personal information or strong emotional reactions. Overall, in spite of efforts to define self-disclosure, the topic remains an uncharted territory for most therapists (Shadley, 2000).

Early Philosophical Perspectives

Historically, psychoanalysts have long argued that only through relative anonymity can the clinician provide a blank screen, thereby allowing transference and subsequent interpretation to take place (Nilsson et al., 1979). One of the aims of this

neutral posture was to prevent the therapist from acting out on countertransference feelings, feelings denoted as personal, which could contraindicate the therapeutic process (Mathews, 1988). Freud acknowledged that a therapist's transference and countertransference to the psychotherapy work would have a certain impact (Mathews, 1988). Consequently, he encouraged therapists to be neutral with their patients, so as to reflect nothing but what was shown to them (Freud, 1912/1959).

In particular, Freud (1912/1959) was wary to single out novice therapists, under the guise they might be tempted to reveal personal information about themselves to their patients so as to draw them out and overcome the narrow confines of their personalities. Moreover, Freud (1912/1959) spoke about the therapists' personalities as a means to overcome the patients' resistances; however, he believed this was to be avoided, likely due to his personal experience. Consequently, Freud advocated the "blank screen" posture, whereby the therapists' neutrality allows the patients' a blank screen upon which to project their feelings (Mathews, 1988).

Nevertheless, Freud did not always follow his own recommendations. Rowan and Jacobs (2002) found that, in Freud's first three decades of psychoanalytic practice, he appeared on a number of occasions to lack awareness of the issues of countertransference and therapist neutrality. One such example was provided by Obholzer (1980) who interviewed one of Freud's former patients. According to Obholzer (1980), this former patient had expressed his tie to Freud had been too strong. Moreover, neutrality had been breached by Freud, evidenced by his extension of financial assistance to this individual, as well as from the report of his disclosures of personal and family information to some of his patients (Obholzer, 1980). In fact, Freud's (1912/1959) personal commentary

acknowledged the value of personal relationships between therapists and their patients (Freud, 1912/1959). Freud (1912/1959) reasoned this was important for the analysis and provision of a personal, reliable, comprehending, reverent, and caring relationship.

Nonetheless, he encouraged therapists to consider the degree to which they promoted the neutral posture (Mathews, 1988). Freud (1912/1959) depicted this as the therapist being likened to a mirror, although not like an inanimate object. Freud (1912/1959) reasoned, given the centrality of the concepts of transference and countertransference, that therapists should be cautioned against too much intimacy, lest it stimulate transference fantasies and distortions. Additionally, he encouraged this position so therapists might avoid the pitfall of acting on their countertransference feelings (Mathews, 1988).

Evolving Debate and Contemporary Perspectives on Therapist Disclosure

Historically, psychoanalytically informed therapists have grappled with Freud's (1912/1958) prophetic mandate to remain opaque, to be likened to a mirror, and to show nothing but what has been shown to them (Geller, 2003). Traditional arguments offered both for and against self-disclosure have been based on one's theoretical preference (Nilsson et al., 1979). In particular, those who have adhered to a traditional model of therapy have advocated for the therapist's neutrality, whereas feminists have argued a "blank slate" stance is an impossible position to fulfill (Enns, 1997).

In the same way, contemporary viewpoints continue to reflect these traditional theoretical differences in regard to the therapists' neutrality (Rowan & Jacobs, 2002). In particular, departures at one end of the continuum, where the therapists' neutrality is valued, the therapists' revelation of personal information to their clients continues to be

seen as a manipulation of the transference. However, at the other extreme--where there is a value given to the therapist's empathic affirmation--abstinence and neutrality are viewed as damaging because they are experienced by the patient as critical acts by an aloof therapist (Rowan & Jacobs, 2002).

In spite of these traditional differences, contemporary viewpoints have loosened from the long-standing status quo of the therapist's neutrality (Knox & Hill, 2003; Thomason, 2005). In fact, some therapists have argued it is impossible to completely eradicate the therapist's presence from the therapy environment (Constantine & Kwong-Liem, 2003; Thomason, 2005). Such elements as the therapist's personality, styles, tastes, and interests might consciously or unconsciously be revealed to the therapist's clients through manner of dress, office décor, and physical appearance (Constantine & Kwong-Liem, 2003). Moreover, the questions one asks or does not ask, as well as one's inadvertent facial expressions, have also been found to be elements that can reveal the therapist's identity to their clients (Kramer, 2000).

Rowan and Jacobs (2002) reported that the trend for the past decade has been a transformation and reconceptualization of the analytic situation. In particular, analytic anonymity has come to be seen as a myth; whereas therapists have come to be seen as a legitimate interpreter of their client's experiences (Rowan & Jacobs, 2002). Moreover, acceptance by therapists of a more liberal interpretation of therapist neutrality—whereby they allow themselves to be personally known by their therapists has come to be substantiated under the guise of the therapist's care towards their clients (Wachtel, 1993).

Psychoanalytic contemporaries have not withheld their comments on this important issue. In fact, some have reported that they have utilized self-disclosure as a

mechanism for their patients to feel the therapists' emotions, critical to an authentic analysis (Billow, 2000). Moreover, evidence has suggested therapist self-disclosure to not only be unavoidable, but also beneficial to the therapeutic relationship and for the growth of one's clients (Goldfried, Burckell, & Eubanks-Carter, 2003).

Geller (2003), a psychoanalytic contemporary, wrote that he utilized self-disclosure more so than did the prototypical psychoanalytically informed therapist. Geller (2003) argued self-disclosure could be just as instrumental as the traditional psychodynamic interventions of clarification and interpretation. However, he admitted self-disclosure remained a low-frequency intervention, and he recommended that if used sparingly, it would be an all the more powerful intervention. Consequently, the self-disclosure debate may have shifted from antagonistic positions to middle-ground acceptance that a therapist's feelings and thoughts might usefully be revealed to one's clients (Knox & Hill, 2003). Nonetheless, although many recent signs have pointed to an increased rationale for the therapist's utilization of self-disclosure (Waska, 1999), as recently as the mid-1990's psychoanalytic proponents could still be found who disagreed with its practice. Their argument was based on concerns that self-disclosure would distort the therapy's transference (Edwards & Murdock, 1994). According to Waska (1999), from a traditional psychoanalytic point of view, in order to gain an adequate degree of insight with one's clients, therapists must keep to minimum actions that might reveal their true selves to their clients. This aim, according to Waska (1999), is meant to increase the likelihood of the client's revealing of unconscious biases and inclinations, characteristics assumed to occur most readily in the condition of ambiguity.

Self-Disclosure in Feminist Therapy

Feminist therapists have often supported self-disclosure in the therapy process (Enns, 1997). Embedded in their theoretical framework and mode of practice has been a number of rationales for its utilization. For one, because clients have often been asked to divulge a number of unsavory elements (e.g., feelings of embarrassment, shame, and pain), self-disclosure has often been justified (Knox & Hill, 2003; Marecek, 2001). Moreover, because of the disparity in how much each counseling party has typically shared, self-disclosure has frequently brought about a therapeutic balance to the therapy relationship (Marecek, 2001).

Other factors have also supported feminists' utilization of self-disclosure. Robitschek and McCarthy (1991) found self-disclosure could be justified as a means to reduce the power differential between both counseling parties, whereas Marecek (2001) reported self-disclosure could be utilized as a means to infuse the elements of hope and recovery into the therapeutic process. Moreover, because clients have often been found to idealize or hold their therapists in awe, self-disclosure has frequently been utilized by feminist therapists so as to be seen as ordinary and fallible human beings (Marecek, 2001). Lastly, self-disclosure has been identified in the feminist's theoretical framework as a means to help illuminate and work through the residue of cultural and value differences, particularly when the therapy has involved clients of a different class or cultural background (Marecek, 2001). However, feminist therapists have not always supported self-disclosure, as discussed in the next section.

Self-Disclosure Issues

Brown and Walker (1990) found one of the most common arguments against self-disclosure was the risk for blurred and obscured boundaries between the therapist, the

client, and their assigned roles. Moreover, they cautioned against self-disclosure because some therapists have discussed their personal problems under the guise of self-disclosure (Brown & Walker, 1990). Additionally, some therapists have misinterpreted feminist efforts to promote egalitarian relationships instead with the establishment of equal relationships as a rationale for self-disclosure, sometimes leading to confusions between friendship and psychotherapy (Hoagland, 1988). Consequently, some clients have inappropriately been placed in the role of the therapist's confidant (Brown & Walker, 1990).

Therapist Frequencies of Self-Disclosure

Self-disclosure has been utilized by a large number of practitioners. In a survey of 346 licensed psychiatrists, psychologists, and social workers, Mathews (1989) found over 80% of her sample reported they had utilized self-disclosure as a therapeutic technique. In another survey of 456 members of APA's Division of Psychotherapy, Pope et al. (1987) found that over 93% of the participants revealed they had utilized self-disclosure. Consequently, self-disclosure is most likely utilized by a large number of practitioners.

Self-disclosure has also been examined from the perspective of the therapist's theoretical orientation. Simone et al. (1998) found, irrespective of one's theoretical orientation, self-disclosure was utilized by a majority of therapists. However, the degree of utilization was found to be moderated by one's level of experience (Simi & Mahalik, 1997). Although many feminist therapists have reported utilizing self-disclosure frequently, they have encouraged other therapists to consider the interaction of such mediating variables (e.g., time, place, rationale, design), as well as the practice of utilizing collegial supervision prior to disclosure implementation (Marecek, 2001).

Inspection of the feminist therapy code of ethics reveals feminists' concerns with the power dynamics of therapy, the egalitarian relationship, and how the therapist's self-disclosure might impact these factors (Feminist Therapy Institute, 1987). Moreover, feminists cautioned therapists not to use self-disclosure to usurp the client's power, but rather to use it to model the effective use of personal power (Feminist Therapy Institute, 1987).

Compared to psychoanalytic/dynamic therapists, feminist therapists have often supported self-disclosure as a mechanism that can lessen the power differential in the therapist-client relationship, validate the client's feelings, and promote a degree of liberation for the client (Marecek, 2001). Self-disclosure has been one of the most widely and frequently used vehicles for power sharing in the feminist therapy process (Marecek, 2001). However, some have questioned the degree to which feminist therapists have utilized self-disclosure (Simi & Mahalik, 1997; Webster, 1986). Webster (1986), for example, explored the most effective interventions utilized by 57 self-identified feminist nurse psychotherapists. A number of interventions were identified which included confrontation, support, and the role-play; however, self-disclosure was not identified as one of their most effective interventions.

In contrast, Simi and Mahalik (1997) found in a survey of 149 female therapists (41 feminists, 34 psychoanalytic/dynamic, 68 other) that therapists of the feminist orientation indicated the greatest agreement with the principles of self-disclosure. Some of the factors unique to feminist therapists included: a willingness to share with their clients salient aspects of their personal background, availability (e.g., allowing a request for self-disclosure), and support for the idea self-disclosure could be utilized to help

empower their clients (Simi & Mahalik, 1997). Additionally, the feminist therapists differed from the analytic/dynamic therapists in terms of the frequency of their utilization of self-disclosure and their motive to utilize disclosure so as to create a more egalitarian relationship. The feminists were most similar to cognitive-behavioral, humanistic, and family-systems therapists in their beliefs that self-disclosure promoted liberatory feelings and was intended to promote the principles of egalitarianism between therapists' and their clients. Consequently, Simi and Mahalik (1997) concluded that self-disclosure is an important technique for the feminist therapist, while also reinforcing the position that one's theoretical orientation determined use of self-disclosure (Mathews, 1988, 1989; Simon, 1988).

Therapist self-disclosure has also been investigated from the client's perspective. Ramsdell and Ramsdell (1993) found that of 67 former clients from a large metropolitan counseling center surveyed, almost 60% indicated that their therapists had shared personal information over the course of therapy. However, self-disclosure was infrequent, with only 15% of clients reporting that their therapist had shared personal information on more than two to three times over the course of their therapy (Ramsdell & Ramsdell, 1993).

Self-Disclosure Rationale

Self-disclosure has been utilized by therapists for a number of reasons, including the promotion of authenticity and psychotherapy productivity (Gabbard, 2003), encouragement of liberty (Simi & Mahalik, 1997), implementation as a momentary buffer to a client's annihilation anxiety, and the provision of trust in the therapeutic relationship (Waska, 1999). Moreover, self-disclosure affords the client power in a

seemingly confrontational environment (Simi & Mahalik, 1997; Waska, 1999), and is justified as a tool for therapist's interpretations of their client's fantasies (Waska, 1999). Weiner (2002), a clinician, reported self-disclosure could be utilized in one of four instances: (a) where it was judged to be instrumental towards saving the life of the patient or therapist; (b) in cases when significant events in the therapist's life could alter the therapeutic relationship; (c) when a particular aspect of the therapist could severely disrupt the clinical relationship; (d) and when a direct interpersonal experience between the therapist and the client would be the only means by which the client could learn important life lessons.

Mathews (1988) conducted a survey of 342 licensed psychiatrists, psychologists, and social workers and found that two of the most common reasons for self-disclosure included the promotion of the feelings of universality, as well as the provision of reality testing. Mathews (1988) reasoned self-disclosure could be justified in the sense the therapist was not unlike the patient, in that both had a past and a present, significant elements crucial to the therapeutic process. In a second study, involving 346 licensed psychiatrists, psychologists and social workers, Mathews (1989) found those who had advocated for self-disclosure considered it a valuable tool for clearing up distorted impressions, which supported transference resistances.

Historically, neutral psychoanalysts have even offered their rationale for the therapist's utilization of self-disclosure. Waska (1999), a present-day psychoanalyst, reported although neutrality and abstinence were necessary and helpful procedures there were times these mechanisms could be loosened. Waska (1999) gave the example of giving one's patients "the facts" so as to pave the road for future interpretations, as well

as to help build temporary trust, with the intent of avoiding a situation in which the patient might flee. Moreover, the provision of facts could help clients feel as though they had some power in the clinical relationship, sometimes perceived as a dangerous and confrontational relationship (Waska, 1999).

Geller (2003), a present day psychoanalyst, identified some of the merits of self-disclosure. For one, self-disclosure could play a role comparable to such interventions as the therapist's use of clarifications, interpretations, and questions, as well as be another way to deliver a message. Moreover, Geller (2003) argued self-disclosure could be just as adaptable as traditionally recognized therapeutic techniques. Waska (1999) reasoned self-disclosure and analytic flexibility were not shifts away from analytic treatment to supportive therapy, but were more of a therapeutic stretching of certain analytic postures, in order to accommodate for moments of extreme difficulty in the patient-therapist dyad.

Self-Disclosure Contraindications

According to Weiner (2002), contraindications regarding the therapists' utilization of self-disclosure have been far more difficult to enumerate than are indications for the therapist's utilization of self-disclosure. However, some have illustrated when self-disclosure should be avoided (Walker & Clark, 1999; Weiner, 2002). For one, Weiner (2002) argued therapists should avoid expressing feelings about a patient if such expressions would make it difficult for the patient to maintain self-esteem; however, he did not provide an example. Weiner (2002) also cautioned against therapists making guarantees they could save the patient's life or psyche. Walker and Clark (1999) identified that if self-disclosures were from a vulnerable therapist, vulnerable in the sense

they were struggling with substance use problems or issues of personal loss, they should be avoided as the therapist might use these disclosures to meet their needs of loneliness.

Researchers have also surveyed why therapists should avoid self-disclosure. Mathews (1988) found some of the most common reasons against self-disclosure were because it shifted the focus away from the client and because it interfered with the transference process. Mathews (1989) found in a second study that more than one third of 346 licensed psychiatrists, psychologists, and social workers agreed self-disclosures that were evidence of countertransference or that diluted the transference were not only contraindicated, but were considered to be anti-therapeutic. However, the survey's participants disagreed as to what degree self-disclosure interfered with the elements of transference and countertransference (Mathews, 1989). Mathews (1989) concluded that the individual practitioners differed greatly in their beliefs concerning self-disclosure.

In sum, the degree one utilizes self-disclosure should be considered when one contemplates the rationale either for or against its usage. Moreover, perhaps one would be wise to heed the words “although some disclosure may improve therapist-patient rapport, excessive self-disclosure with role reversal may initiate a downward spiral leading into more serious boundary violations, such as with sexual involvement.”

(Gabbard & Nadelson, 1995, p.1448).

Self-Disclosure Research Findings

Benefits

Researchers have revealed self-disclosure to have several benefits for the client. Derlega, Metts, Petronio, and Margulis, (1993) found self-disclosure contributed to the development of a close relationship as well as to its maintenance. Moreover, Simone et

al. (1998) found self-disclosure results in greater levels of client-counseling satisfaction as well as an increased likelihood of the client's return for additional counseling sessions. Murphy and Strong (1973) explored the benefits of self-disclosure from the client's perspective, identifying when self-disclosures were utilized by therapists. The clients of these therapists were more likely to see their therapists as friendly, open, helpful, and warm.

Similarly, Barrett and Berman (2001) investigated the benefits of self-disclosure from the client's perspective. Results of their study of 18 therapists and 36 clients indicated that those who had received increased therapist self-disclosures reported greater reductions in symptomatic distress and an increased affinity for their therapists, compared to those who received limited self-disclosures. Additionally, Barrett and Berman (2001) reported these findings were not unlike the claims of other therapists (Derlega, Metts, Petronio, & Margulis, 1993; Jourard, 1971; Kaiser, 1965) who argued self-disclosure could enhance the relationship between the therapist and the client.

Negative Effects

A number of authors have addressed the dangers of therapist self-disclosure (Anderson & Mandell, 1989; Mathews, 1988, 1989). Some believe self-disclosure can be a frightening venture for the client, especially if it exposes the discloser to rejection or indifference (Derlega et al., 1993). Moreover, some have cautioned its use due to the possibility some practitioners will utilize self-disclosure to satisfy their personal goals, antithetical to the needs of the other person (Derlega et al., 1993). Self-disclosure may also shift the focus away from the needs of the client to the needs of the therapist (Anderson & Mandell, 1989; Mathews, 1988, 1989), while also interfering with the

transference process (Anderson & Mandell, 1989; Mathews, 1988, 1989). Lastly, self-disclosure can be detrimental because it reduces the opportunity for the client's disclosure, as well as creates role confusion (Anderson & Mandell, 1989).

Paucity of Research

Ever since Jourard (1971) began the study of self-disclosure in the 1950's, efforts to gather objective data from the practice of psychotherapy have revealed little in the way of objective data. Apart from theoretical arguments about therapist self-disclosure, psychotherapy research has not assessed the impact of therapist disclosure on treatment outcomes (Barrett & Berman, 2001). Moreover, research has been limited, specifically, when it has concerned the clinical application of therapist self-disclosure (Simon, 1988). For example, Goldfried et al. (2003) found little research when it concerned self-disclosure in the context of cognitive-behavior therapy.

Self-Disclosure Valence: Similar and Dissimilar Forms

Similar and Dissimilar Self-Disclosure Defined

Murphy and Strong (1973) described similar self-disclosure as congruence between a therapist's and a client's shared experience; whereas a dissimilar self-disclosure entails incongruence between a therapist's and a client's shared experience. Similarly, Watkins (1990) reported a similar self-disclosure as disclosure made by Person A which is consistent or similar to a disclosure made by Person B; whereas a dissimilar self-disclosure was said to be a disclosure made by Person A which was inconsistent with a disclosure made by Person B.

Similar and Dissimilar Self-Disclosure Research Findings

Bandura (1971) suggested that a reduction in anxiety could be found for those who witnessed others with similar behavior. Several studies investigated Bandura's proposition, particularly in the sense of how the therapist's utilization of similar self-disclosures would be received by another. In one case, Giannandrea and Murphy (1973) investigated the effects of a male interviewer's similar self-disclosures, as well as the timing and frequency of these disclosures, on a subject's return behavior for a second interview. Their study utilized a sample of 50 college males where an advanced, male counseling psychology student conducted the therapy, disclosing experiences, attitudes, and feelings similar to those revealed by the student subjects. Similar disclosures were made 0, 2, 4, 8, and 12 times during the course of a single 20-minute interview (Giannandrea & Murphy, 1973). The 50 subjects were randomly assigned to five groups of 10, with each group being assigned to one of the frequency of disclosure conditions (i.e., 0, 2, 4, 8, and 12). The authors found that an intermediate or moderate number of disclosures resulted in significantly more students returning for a second interview than did few or many disclosures. This suggests the initial use of a moderate number of similarity self-disclosures to be an effective technique towards the achievement of a positive client/therapist working relationship. However, the researchers questioned whether it was the similarity of the disclosures, the number of disclosures, or some combination which led to the increased return of subjects for a second interview. Giannandrea and Murphy (1973) speculated that too many disclosures might have led to there being too little time for the subjects to interact, compared to the condition which involved the moderate number of disclosures (Giannandrea & Murphy, 1973). Moreover,

for those groups who received the fewest similar disclosures, this may have led to a failure for effect (Giannandrea & Murphy, 1973).

Mann and Murphy (1975) also investigated the effects of similar disclosure at a varied frequency. They examined the effects of an interviewer's self-disclosures on recipients' reciprocation of disclosures. Moreover, these effects included not only the recipients' reactions to the interviewer, but also whether interviewer disclosures made prior to recipients' self-disclosures increased the recipients' disclosures Mann & Murphy, 1975). Their study included 54 college female subjects, who were individually interviewed by a female interviewer over a 40 minute period of time. The interviewer disclosed similar and dissimilar experiences, attitudes, and beliefs, in response to those revealed by subjects at 0, 4, and at 12 times. Such disclosures were arranged to occur either prior to (modeling condition) or immediately after (reinforcement condition) the subject's disclosures. The authors found that an intermediate number of self-disclosures resulted in significantly more subject disclosures than either many or no disclosures. Consequently, a position could be substantiated that an intermediate number of self-disclosures were instrumental in the initiation of the reciprocity of disclosures (Mann & Murphy, 1975). However, similar findings were found for both the similar and dissimilar disclosures (Mann & Murphy, 1975). Consequently, the researchers were forced to conclude the element of similarity was only one of the contributors to positive recipient perceptions (Mann & Murphy, 1975). Mann and Murphy (1975) recommended future research explore this issue further via the increased systematic control of similar versus dissimilar disclosures. The element of timing, modeling (i.e., self-disclosure prior to

client) versus reinforcement (i.e., self-disclosure after the client's disclosure), was not found to have a significant effect upon the outcome of the study.

Cash and Salzbach (1978) examined the effects of therapist self-disclosure, varying the therapist's physical attractiveness. The authors postulated that the therapist's physical attractiveness would bias the observers' early evaluative reactions and expectations, and the nature and extent of these effects depended on the nature and the extent of the therapist's disclosures utilized during the initial interview. Their study, analogue in design, involved 144 Caucasian female undergraduates who volunteered for credit applied towards the fulfillment of an introductory psychology course requirement. Cash and Salzbach (1978) found in their comparison of nondisclosing attractive and nondisclosing unattractive male therapists, that the unattractive therapist was viewed less favorably in regard to expertise, attractiveness, trustworthiness, in addition to facilitative conditions of empathy, regard, and genuineness. However, the unattractive therapist's utilization of a moderate amount of similar demographic and personal disclosures to their clients improved their status on all facilitative conditions and measured trait attributions (e.g., facilitative conditions of empathy, regard, and genuineness) (Cash & Salzbach, 1978). Additionally, the therapists' utilization of personal disclosures strengthened the subjects' confidence toward all of the therapists, including the unattractive ones (Cash & Salzbach, 1978). Lastly, Cash and Salzbach (1978) reported even though the therapists in their study had avoided personal disclosures of promising solutions such as disclosures of positive feelings and experiences to their clients, they did share disclosures similar to their clients in terms of past negative feelings and experiences. Compared with nondisclosure, only the personal-disclosure condition was successful towards the

subjects' optimistic expectation of a continuation of counseling services (Cash & Salzbach, 1978).

Additionally, Peca-Baker and Friedlander (1989) investigated the impact of therapist disclosure. They noted that although much evidence could be found in support of therapist disclosure, it was unclear whether this support was for the act of disclosure or the personal information which comprised it. Their research involved a live quasicounseling analogue study, comprised of 60 undergraduate female students. Their investigation contrasted (a) therapists who disclosed personal material similar to the client's problem, (b) therapists who disclosed problematic but irrelevant information, (c) therapists who provided no disclosure, and (d) therapists whose similar information was revealed by someone else. The results of their investigation indicated type of self-disclosure had no differential effect upon the participants' perceptions of the female therapists (Peca-Baker & Friedlander, 1989). Their hypothesis that a therapist's similar self-disclosures would lead to greater ratings of therapist attractiveness, trustworthiness, and empathy compared to dissimilar self-disclosures was not supported. However, post-experimental structured interviews indicated that not only did therapist disclosure have an impact but the similarity of the information upon the participants' experience did as well.

However, there were a number of limitations with Peca-Baker and Friedlander's (1989) study: (a) They used an analogue research design, (b) they used only undergraduate students as representatives of actual clients, and (c) they used only female therapist and client roles. In addition, the researchers' quasi-counseling scenarios only covered the first few minutes of a counseling session, which limited the effects of disclosure to the first few minutes of a counseling session.

In a more recent analogue study, Nyman and Daugherty (2001) utilized 67 undergraduates (24 men, and 43 women) who rated a gender-neutral therapist on expertness, trustworthiness, and attractiveness. Participant ratings were based on their reading of one of two randomly assigned session transcripts, one which contained a congruent self-disclosure, the other an incongruent self-disclosure. The congruent self-disclosure was a therapist's reciprocation of a similar piece of information to their client's, whereas the incongruent self-disclosure entailed a therapist's disclosure of information unprompted by a client's disclosure (Nyman & Daugherty, 2001). Nyman and Daugherty (2001) found the congruent self-disclosure resulted in more favorable ratings compared to an incongruent self-disclosure.

In sum, several investigations demonstrated benefits that can come from therapist's similar and congruent self-disclosure (Cash & Salzbach, 1978; Giannandrea & Murphy, 1973; Mann & Murphy, 1975; Peca-Baker & Friedlander, 1989; Nyman & Daugherty, 2001). In particular, similar self-disclosures lead to favorable recipient ratings (Nyman & Daugherty, 2001), positive subjective recipient comments (Peca-Baker & Friedlander, 1989), greater return of subjects for a second interview (Giannandrea & Murphy, 1973), increased level of recipient self-disclosure (Mann & Murphy, 1975), and increased ratings on therapist facilitative conditions and trait attributions (e.g., empathy, regard, and genuineness) (Cash & Salzbach, 1978). However, one is cautioned against accepting these results at face value, due to the influence of other variables (e.g., frequency of use) (Cash & Salzbach, 1978; Giannandrea & Murphy, 1973; Mann & Murphy, 1975).

Limitations in research on similar, dissimilar, congruent, and incongruent self-disclosure were found to exist in the context of the gender composition of the therapy dyad. To date, of the five studies reported, none explored the effects of self-disclosure in the context of varied gender arrangements of the therapy dyad (Cash & Salzbach, 1978; Giannandrea & Murphy, 1973; Mann & Murphy, 1975; Peca-Baker & Friedlander, 1989; Nyman & Daugherty, 2001). Moreover, three of the studies explored self-disclosure; however, they only utilized same-gendered clients and therapists (Giannandrea & Murphy, 1973; Mann & Murphy, 1975; Peca-Baker & Friedlander, 1989); whereas Cash and Salzbach (1978) only utilized subjects and one therapist of the same gender (Cash & Salzbach, 1978). Lastly, in the final study, the gender of the therapist was not identified at all (Nyman & Daugherty, 2001). Consequently, investigations into similar versus dissimilar forms of disclosure have not taken into consideration the factor of gender and how it might moderate the effects of self-disclosure, one of the chief aims of this study.

Self-Disclosure Research Recommendations

In a review of research on self-disclosure, spanning the early 1970's to the late 1980's, Watkins (1990) made several recommendations for future self-disclosure research. First, he recommended researchers address the interactive effects between gender traits, subject sex, and the therapist's self-disclosure, because prior investigations had typically only investigated the influence of one sex's disclosure upon another. Moreover, he advised researchers to consider the variables of client and therapist gender traits and sex-role orientations in future self-disclosure investigations.

Second, Watkins (1990) saw a need to utilize college students who were actual clients, or to utilize those who were psychologically distressed or from other age groups.

He reasoned if this were not the case, research should at least investigate the subject's ability to identify with the role of the client. The current study's review included similar self-disclosure investigations involving only subjects from a college-age student population (Cash & Salzbach, 1978; Giannandrea & Murphy, 1973; Mann & Murphy, 1975; Murphy & Strong, 1973; Nyman & Daugherty, 2001; Peca-Baker & Friedlander, 1989). Third, Watkins (1990) encouraged future researchers to address the interactive effects of self-disclosure, because much of the self-disclosure research had only been unilateral in its execution (e.g., the counselor self-disclosed and the effects on the client were studied). He reasoned many of the variables could be interactive and critical in their mediation effects upon the self-disclosure (e.g., content, timing, and client expectation). However, of the studies presented, none gave consideration to such a mediating factor but some varied self-disclosure by its frequency, timing, type, as well as by who prompted the self-disclosure (Cash & Salzbach, 1978; Giannandrea & Murphy, 1973; Mann & Murphy, 1975; Murphy & Strong, 1973, Nyman & Daugherty, 2001; Peca-Baker & Friedlander, 1989).

Fourth, Watkins (1990) noted the need to establish a greater consistency with the language that defined self-disclosure. This appeared particularly problematic with regard to the similar and dissimilar types of self-disclosure. Nevertheless, Watkins (1990) found evidence some efforts had been made to address this very issue. In particular, he cited the development of Cormier and Cormier's (1985) two-dimensional model and its usefulness towards the development of a consistent definition for both similar and dissimilar types of self-disclosure. Moreover, he used this model to define similar disclosures as those

disclosures made by Party A which were consistent with or similar to those made by Party B (Watkins, 1990).

Wachtel (1993) also referred to the problem of how self-disclosure was defined, citing the vast number of definitions. What is more, he reported the issue was further complicated because many therapists questioned whether they should or should not disclose something personal about themselves to their clients. Additionally, he noted that clinical discussions often did not distinguish among the various kinds of disclosures, or among the different ways information about the therapist could be conveyed. Furthermore, Wachtel (1993) cautioned he did not find all disclosures to be appropriate in any given clinical situation, but some to be generally more useful than others.

Fifth, Watkins (1990) encouraged research efforts to address the effects of the self-disclosure past the initial interview, because many studies had only focused on the initial interview. Such results revealed very little data on the longitudinal effects of self-disclosure. Of the studies reviewed in this investigation (Cash & Salzbach, 1978; Giannandrea & Murphy, 1973; Mann & Murphy, 1975; Murphy & Strong, 1973; Nyman & Daugherty, 2001; Peca-Baker & Friedlander, 1989), only Giannandrea and Murphy's (1973) investigation explored the effects of self-disclosure beyond the initial therapy session.

Sixth, Watkins (1990) argued there was a certain discrepancy between therapist self-disclosure research and what had actually been taught in introductory therapy textbooks and therapist training programs. He indicated therapist self-disclosure was often taught as something to be avoided until the therapy relationship had been established. However, self-disclosure research appeared misguided, because many

investigations had only looked at self-disclosure and its effects from the vantage of the initial interview, as well as its impact over brief segments of therapy time (e.g., 5 to 10 minutes) (Watkins, 1990). Lastly, Watkins (1990) found that much of the research he reviewed addressed only how therapist's self-disclosure affected the perceptions of the client. However, little research could be found on how self-disclosure affected clients' behavior (Watkins, 1990).

Gender and the Treatment Dyad

Male Client/Male Therapist Treatment Dyad

In terms of the male client/male therapist treatment dyad, men have rarely relied upon one another for help (Scher, 2005). Such elements as the male's gender role have influenced not only what has brought men into therapy but also how their therapy has proceeded (Scher, 2005). Intimacy has been a particularly difficult issue, due in part to its direct relationship with the male's vulnerability (Scher, 2005). Consequently, the establishment of intimacy has required male clients to move beyond the limitations of the male gender role. This places the burden on male therapists to be cognizant of the male client's fear towards others as well as the importance of concern, good humor, and interest for the treatment of men (Scher, 1979).

Additionally, the initial contact between male therapists and their male clients has also been considered. For one, male therapists have been cautioned to restrain affection and to be aware their therapy with male clients will necessitate a great deal of patience and skill (Scher, 2005). Moreover, the element of time has also been discussed, with male therapists being encouraged to allow new ideas to occur over time, especially those which involve one's feelings (Robertson, 2005). Also, Robertson (2005) believed time would

allow male clients over the long haul to build up a repertoire of skills, including emotional expressiveness, comfort with intimacy, and a desire to share power and resources. Furthermore, Robertson (2005) recommended male therapists to work slowly with males clients when this involved the emotional work of therapy. He reasoned that this would provide time, so as to be able watch for their clients' expressions of anxiety and fear and be able to normalize these.

The novelty of the therapy situation has also been considered for the male client. Robertson (2005) encouraged male therapists to use familiar words, so as to alleviate the novelty of the therapy process and to promote the male client's transition into the therapy process. Moreover, because the dialogue of therapy has often been found to be "gendered"--in the sense males are more likely to interrupt and determine the nature of the conversation than are females--male therapists have been advised to avoid the unfortunate events of their clients not feeling heard (Gilbert & Scher, 1999). Lastly, male therapists should also model to their male clients' awareness of their emotions (Robertson, 2005). Such awareness liberates male clients from the constraints of the stereotypical male role (Scher, 2005).

Female Client/Female Therapist Treatment Dyad

Researchers have found female clients prefer therapy with female therapists (Howard, Orlinsky, & Hill, 1970), especially in matters constituted of personal concern (e.g., relationship issues) (Bernstein, Hofmann, & Wade, 1987; Blier, Atkinson, & Greer, 1987; Boulware & Holmes, 1970). Included in these findings have been cases of the rape survivor (Yanico & Hardin, 1985). Fowler, Wagner, Iachini, and Johnson (1992) explored therapist gender preferences of 35 sexually abused girls between the ages of 5

and 17. The authors found 71%, or 25 of the subjects, expressed a preference for a female therapist, whereas 20% stated they had no preference. The remaining 9% indicated a preference for a male therapist (Fowler et al., 1992). However, a potential limitation existed because the interviewer who had solicited the girls for their therapist preference was a man. The authors reasoned this potentially prohibited the abuse victims from expressing their clear preferences in terms of the therapist's gender.

Others have also examined women's preference for the female/female therapy dyad. For instance, Blase (1977) found female clients of female therapists to be satisfied; Kaschak (1978) and Kirshner, Genack, and Hauser (1978) also found female clients of female therapists had greater ratings of improvement and satisfaction than clients of other client/therapist gender pairings. However, female clients do not always prefer female therapists. In fact, Dailey (2004) found female clients who worked with female therapists struggled with discussions on key psychotherapeutic topics. Moreover, these clients expressed great concern about the impact of their disclosures upon the feelings of their female therapists (Dailey, 2004). Additionally, in one early study, female clients preferred therapy with male therapists (Fuller, 1963). Lastly, some evidence has found the sex of the therapist is unrelated to the client's overall improvement (Blase, 1977).

Some specific recommendations have been made regarding the female client and the therapist dyad. For instance, in the context of abuse, male therapist/female client dyads are not always recommended, based upon the assumption male therapists may abuse their female clients (Fowler & Wagner, 1993). In addition, sexually abused girls fear men more so than do nonsexually abused girls (Briere & Runtz, 1988). In contrast, potential problems may arise in some female/female dyads, if the female therapist forms

an alliance with her female clients against all men (Fowler & Wagner, 1993). However, female therapists should express empathy for the negative effects of societal expectations placed upon women (Johnson, 2005).

Male Client/Female Therapist Treatment Dyad

On the whole, male clients have utilized female therapists more so than male therapists (Johnson, 2005). Such reasons have included male expectations that female therapists, by default of their gender, are more knowledgeable about relationship issues (Johnson, 2005). Moreover, men frequently believe if they express their emotions or vulnerabilities, it is less shameful in the safer context of the female therapist (Johnson, 2005). Additionally, male clients frequently seek out female therapists because most male relationships have been perceived by men as highly competitive (Johnson, 2005; Scher, 2005). Consequently, male clients have avoided male therapists due to their belief female therapists will be different and will not taunt or tease them for their failures (Johnson, 2005).

However, male clients have concerns about the power of female therapists, power in the sense that their expression of feelings to their therapist will equate to their relinquishment of power (Scher, 1990; Silverberg, 1986). Power in this case is the ability to determine one's own life (Smith & Siegel, 1985). As such, female therapists have been advised to consider the element of power (Scher, 1990; Silverberg, 1986). For instance, Johnson (2005) recommended female therapists be sensitive to their own feelings about power and control, so as to avoid their contamination of an effective interpretation. Moreover, she encouraged female therapists to be more aware about gender issues,

facilitated by their utilization of gender-sensitive and gender-aware therapies (Johnson, 2005).

Furthermore, female therapists have been encouraged to become aware of male clients' competition for both nurturance and the expectation they be powerful and in control (Fischer & Good, 1997; Levant, 1992; Napier, 1991). This encouragement has been based on male clients' ambivalence towards the female therapists (Fischer & Good, 1997; Levant, 1992; Napier, 1991). Consequently, female therapists have been encouraged to become aware of these dual societal expectations, to continue to nurture men, and to allow men their retention of personal authority and power (Johnson, 2005). As such, female therapists must struggle with their support for the male client's efforts to grow, while also being confronted with the client's attempts to remain the same (e.g., remain silent about shameful feelings, hold to male assumptions in regard to male power and privilege) (Johnson, 2005). Moreover, recommendations have been made for female therapists to avoid shame with their male clients, as this feeling has been found to be particularly difficult, especially to those who have been held hostage to a rigid adherence to the male role (Erickson, 1993). Lastly, female therapists have been cautioned about the initial scenario of the therapy situation, due to their possession of power from many perspectives, including the fact they are knowledgeable about the language of therapy (Erickson, 1993). Thankfully, steps can be made towards the equalization of the power balance between female therapists and their male clients, such as in the case of female therapists teaching their male clients about the language of feelings (Johnson, 2005).

Female Client/Male Therapist Treatment Dyad

Lastly, female client/male therapist treatment dyads have been considered in investigations of gender and treatment interactions. Fowler and Wagner (1993) conducted a study with 20 sexually abused girls from the ages of 7-15 who received six sessions of psychoeducationally based individual therapy from either male ($n = 10$) or female ($n = 10$) therapists. Fowler and Wagner (1993) found the participants who were treated by the male therapists expressed significantly greater preferences for and anticipated more comfort with male therapists after the completion of the treatment program than did their counterparts treated by the female therapists. Moreover, they also found the participants treated by the male therapists were not significantly more or less comfortable with their assigned therapists following the completion of the treatment as compared to those who were treated by the female therapists.

Summary of Treatment Dyads

Research on client-therapist gender preferences has revealed ambiguous results (McKinnon, 1990) and inconsistent findings (Fowler & Wagner, 1993). For instance, several studies found clients of both genders to slightly prefer male therapists; however, female clients were found to prefer female therapists in matters of “personal concern” (Bernstein et al., 1987; Blier et al., 1987; Boulware & Holmes, 1970). Moreover, clients seen by therapists of the same sex are more satisfied (Blase, 1977) and stay in treatment for longer periods of time (Zones & Zoppel, 1982). Results have even evidenced the sex of the therapist to not be influential on the client’s overall improvement (Kaschak, 1978), whereas other studies have indicated female therapist-client dyads to have greater improvements and satisfactions with treatment than clients involved in other therapist-

client dyads (Kaschak, 1978; Kirshner et al., 1978). Consequently, it is a struggle to find consistent findings.

Working Alliance Defined

A number of definitions have been offered for the working alliance (Bordin, 1976; Gelso & Carter, 1985; Sterba, 1934; Zetzel, 1956). Gelso and Carter (1985) described the working alliance as the care the client and the therapist feel towards one another, as well as the perceived notion both parties work productively towards a shared goal. Although there have been a number of definitions, there has been no universally accepted definition for the working alliance concept (Horvath & Luborsky, 1993; Saketopoulou, 1999).

Over the course of the 20th century, the concept of the working alliance has undergone a number of revisions. The original concept was said to be owed to Freud; however, he did not coin the term (Horvath & Bedi, 2002). Freud (1913/1958) reported the alliance was not only the dyadic interaction between both members of the dyad, but also the therapist's collaboration with the client. Moreover, this definition also included the client's encouragement of warm feelings towards the therapist (Freud, 1910/1957).

Sterba (1934) also provided a conceptualization of the working alliance, termed the ego alliance. Sterba (1934) depicted the alliance as an encouragement of the client's identification with the therapist, designed to help draw the client's ego towards the therapist's side. As a consequence, it was hoped this alliance would allow the client to see issues from a new point of view, as well as to eliminate impediments to the therapy's progression.

Zetzel (1956) termed the concept of the working alliance “the therapeutic alliance.” Zetzel (1956) identified the therapeutic alliance was the client’s ability to use the healthy part of the ego in order to join the therapist to accomplish therapeutic tasks. Moreover, this alliance resulted from the client’s identification with the therapist, a precursor to the client’s ability to withstand the transference-analysis process (Zetzel, 1956).

Greenson (1967) was credited as the first to have coined working alliance. Greenson (1967) realized there was a positive collaboration between the client and the therapist, which was paramount and one of the most essential components for successful therapy. Greenson (1967) believed this alliance was comprised of the client’s motivation and the ability to work in the treatment interaction, while also resting on specific contributions made from the client, the therapist, and from the therapeutic interaction. Client contributions consisted of the client’s motivation to overcome the problem, a sense of helplessness, a rational willingness to cooperate, and the ability to follow and grasp the insights of the therapist. Therapist contributions emphasized understanding and insight, as well as the possession of an empathic, compassionate, and nonjudgmental attitude. Contributions from the treatment situation encompassed such elements as respect of the therapy enterprise as a joint venture, as well as the elements which concerned the regularity and orderliness of work routines and the consistent pursuit of insight.

A more recent operational definition of the working alliance was given by (Bordin, 1976) who proposed the working alliance included both the therapist’s and client’s agreement on the goals and tasks of therapy, as well as the development of the bond between both members of the therapeutic relationship. Presently, Bordin’s

definition is the one most widely held by both researchers and practitioners (Good & Mintz, 2005). In terms of its constituted elements, goals are the objectives or targeted outcomes of the therapeutic intervention; whereas the tasks refer to in-therapy behaviors and cognitions that form the substance of the therapeutic process (Good & Mintz, 2005; Horvath, 1994). Lastly, the therapeutic bond is comprised of a complex network of positive personal attachments between both the client and the therapist (Beitman & Yue, 1999; Bordin, 1976; Horvath, 1994). This bond embodies the meaning of the counseling relationship held by its members, considered one of the most delicate issues the therapist must address in work with a male client (Good & Mintz, 2005).

Bond, task, and goals, elements of the working alliance are all critical to the therapeutic outcome between the client and the therapist. In fact, these elements define the quality and the strength of the therapeutic alliance (Bordin, 1976) which, although not a cure, makes it possible for the client to accept and follow therapy (Bordin, 1980). According to Horvath and Luborsky, (1993), installation of the alliance requires that therapists communicate to the client important linkages between therapy tasks and overall goals of treatment, while also giving consideration to client resistance and intervention if necessary. One must also consider the element of time as a critical factor in terms of task and goal elements of the alliance. According to Horvath and Luborsky (1993), therapists and clients are not always in agreement as to the goals of therapy, or the time in which to accomplish these. They recommend that the therapist should attempt to negotiate between clients' immediate expectations and their desire to have long lasting pain relief. According to Horvath and Luborsky (1993), the illustration of these linkages will

generate a stronger working alliance and allow the client to pursue the therapy's objectives.

The Working Alliance and Outcome

Research indicates there is a relationship between the strength of the working alliance and therapy outcome (Gelso & Carter, 1985; Horvath & Greenberg, 1989; Moras & Strupp, 1982). Horvath and Symonds (1991) found an overall effect size [ES] of .26 between alliance and outcome based upon a meta-analysis of 24 studies. In a more recent meta-analysis, an [ES] of .22 was found from a review of 79 studies (Martin, Garske, & Davis, 2000).

Other findings have also supported the instrumental nature of the working alliance. For instance, some researchers found a positive alliance is associated with more positive client and counselor evaluations of sessions with respect to smoothness, depth, and positivity (Mallinckrodt, 1993; Myers, 2004), as well as the general finding that a positive alliance could contribute to a more favorable outcome (Connors, Carroll, DiClemente, Longabaugh & Donovan, 1997; Horvath & Symonds, 1991). Moreover, a positive alliance leads to positive therapist ratings (Myers, 2004).

Several studies have demonstrated a link between the working alliance and therapy outcome (Gaston, 1990; Horvath & Symonds, 1991). For instance, some theorists believe a positive alliance is a prerequisite to effective interventions, because it provides a safe environment and the interpersonal reinforcement the client needs to tolerate anxiety aroused from the therapy's interventions (Greenson, 1967; Teyber, 1991). In one study, Mallinckrodt (1993) assessed the relationship between a number of measures of therapy outcomes and the working alliance in a sample of 41 counseling dyads,

comprised of 61 clients and 30 student counselors. He found that client session evaluations were positively related to subsequent alliance ratings, and that positive alliance ratings predicted subsequent session evaluations. Mallinckrodt (1993) reasoned his research was unique in the sense he explored therapist disclosure effects at the end of separate therapy sessions versus at the end of therapy. He argued that this latter approach might only capture the cumulative effects of therapist disclosure and mask the effects of individual therapy sessions. Consequently, Mallinckrodt (1993) found phase of therapy relationship to have an instrumental relationship on the effectiveness of the therapist's implementation of disclosure. In particular, degree of smoothness (i.e., how relaxed, easy and comfortable the client was) impacted working alliance ratings and should be considered for the relationship between the therapist's disclosure and the working alliance. Consequently, this suggests one should take into consideration the complex relationship between therapist disclosures, the phase of the therapy relationship and how these factors affect the working alliance.

Recently, Myers (2004) investigated how self-disclosing therapists were viewed by observers, if they self-disclosed in the context of both positive and negative working alliances. Results indicated that for weak client-therapist working alliances, therapist self-disclosures led to more negative evaluations of the therapist in terms of expertise versus the more favorable findings of disclosures made in the context of strong working alliances (Myers, 2004). Consequently, some evidence supports the instrumental nature of the working alliance and its benefit to the clinical setting.

Working Alliance and Gender

Research indicates the working alliance is unique for both genders. Dailey (2004) hypothesized one's gender-role identification would predict differences in self-disclosure more so than would biological gender. For instance, men who are highly identified with the male gender role will disclose less and have weaker therapeutic alliances than either men who identify less with the male gender role, or even women (Dailey, 2004). Those constituted to be androgynous were expected to disclose more than those who were not androgynous. In addition, Dailey (2004) posited the strength of the working alliance would have a significant impact upon one's disclosure, when controlling for the client's gender.

Results of Dailey's (2004) study found: (a) women, compared to men, disclosed more in the context of stronger working alliances; (b) women working with female therapists had greater difficulties discussing intimate material than did either men, or women working with male therapists; (c) female clients who worked with female therapists experienced greater levels of concern about the impact of their disclosures than did male clients and female clients working with male therapists. Lastly, those with androgynous gender-role identifications disclosed more than did those other gender-role identifications (Dailey, 2004). This latter finding suggests that one's biological gender alone does not sufficiently explain their utilization of self-disclosure, but also the strength of their adherence to their gender-role.

One of the most delicate issues for the therapist concerns establishing an effective working relationship with a male client (Good & Mintz, 2005). Some men come to counseling because someone else has pressured them to attend, an impediment further complicated by their not knowing what exactly they need to change. This struggle has

also been hampered by some men's ambivalence toward their emotional transparency, which is a consequence of men's socialization toward self-sufficiency and immunity from interpersonal vulnerability (Good & Mintz, 2005). In fact, Moras and Strupp (1982) found a positive relationship between having a good history of interpersonal relationships and one's ability to form an alliance. Gelso and Carter (1985) addressed the relationship between the working alliance and one's interpersonal relationships. These authors reported, in general, the ability to form a sound alliance was related to the capacity to form productive attachments to others, a capacity to trust others, and a willingness to take responsibility in the work of counseling. Therefore, several factors contribute to the interaction between one's prior relationships, their impact upon the working alliance, and one's interpersonal relationships.

Other factors have also been considered in investigations concerning the working alliance and the therapeutic encounter. For instance, one of the initial steps when attempting to promote the development of the working alliance for the male client is to establish goals for treatment, because strong working alliances are characterized by mutual endorsement and valuing of shared goals (Good & Mintz, 2005). Moreover, therapists should attempt to normalize the cultural and familial socialization processes which have conditioned the male client in his strivings toward invulnerability (Good & Mintz, 2005). Lastly, therapists should promote the legitimacy of their client's concerns through a process of reflection, while also acknowledging the strength it took their client to seek out resolution (Good & Mintz, 2005).

The Working Alliance and Self-Disclosure

The working alliance is crucial to the therapeutic enterprise, because it embodies the quality and strength of the collaborative relationship between the client and the therapist (Horvath & Bedi, 2002). Researchers have investigated the therapeutic factors that contribute to the working alliance, as well as the components that comprise it, especially the therapeutic bond between the client and the therapist (Horvath & Bedi, 2002). Some speculate there is a relationship between the therapist's self-disclosure and the working alliance (Dailey, 2004; Myers, 2004). Moreover, they reason disclosures of a congruent or similar type may increase the perceived similarity between the client and the therapist as well as hasten the formation of the therapeutic bond (Nyman & Daugherty, 2001). Edwards and Murdock (1994) surveyed a group of licensed psychologists as to their rationale for self-disclosure. The surveyed psychologists reported, on average, their intent was to promote the increased similarity between themselves and their clients (Edward & Murdock, 1994).

The timing of self-disclosure and its interaction with the working alliance have also been investigated. Myers (2004) reported the working alliance should be cultivated prior to any self-disclosure. In the case of a weak working alliance, therapist disclosures (general and countertransference disclosures) led to more negative client evaluations of the therapist in terms of expertise and the session's depth than did no disclosures. However, in the case of a strong working alliance, therapist self-disclosures led to more favorable client ratings on expertness and session depth when they self-disclosed (Myers, 2004). Consequently, the judicious utilization of self-disclosure appears to be supported, whereas disclosures made before the formation of strong working alliances appear to be counter therapeutic (Myers, 2004).

Conversely, self-disclosure can also repair a rupture in an already existent therapeutic alliance (Safran & Muran, 1996). The therapist's self-disclosure can also engage highly reactant clients (those who rebel against directions from others) (Beitman & Yue, 1999). Lastly, sharing genuine reactions with a client can enhance the meaningfulness of therapeutic relationship (Good & Mintz, 2005).

Summary

In sum, although self-disclosure investigations have examined a large number of research variables--such as the impact of therapist self-disclosure upon the client (Giannandrea & Murphy, 1973; Nyman & Daugherty, 2001; Peca-Baker & Friedlander, 1989) and theoretical arguments for and against self-disclosure (Knox & Hill, 2003), research on the effects of self-disclosure on the working alliance is limited. This literature review identified only two studies that had investigated self-disclosure and its relationship with the working alliance (Dailey, 2004; Myers, 2004); however, neither study examined the direct effects of self-disclosure upon the working alliance (Dailey, 2004; Myers, 2004), one of the chief aims of this study.

In addition, this literature review revealed no studies of self-disclosure influences in varied therapy-gender arrangements (e.g., male therapist/female client, female therapist/male client, female therapist/female client, and male therapist/male client). Furthermore, many of the studies utilized only female participants (Dailey, 2004), and many had only considered the influence of one gender's utilization of self-disclosure upon another (Watkins, 1990). Therefore, the present study examines self-disclosure in the context of varied therapy-gender arrangements.

Lastly, although some studies have investigated the impact of the self-disclosure valence (e.g., similar versus dissimilar) upon the therapist's attractiveness and expertness (Cash & Salzbach, 1978; Giannandrea & Murphy, 1973; Mann & Murphy, 1975; Nyman & Daugherty, 2001; Peca-Baker & Friedlander, 1989), none has examined these effects upon the working alliance, particularly, in the context of mixed-gender therapy arrangements. It is hypothesized that manipulations of the self-disclosure's valence (similar versus dissimilar versus no disclosure) and of the therapeutic dyad (male therapist/male client; female therapist/female client; male therapist/ female client; female therapist/male client) will affect observer working alliance ratings of the therapy relationship. Listed are the following research questions and hypotheses.

Research Questions & Hypotheses

Research Question One – Are there differences in observer ratings of the working alliance based on the type of disclosure (i.e., Is there main effect for disclosure type?)

Hypotheses

Hypothesis I: Male observers will rate male therapists utilizing no disclosures with male clients as having a stronger working alliance versus male therapists utilizing similar disclosures with male clients.

Hypothesis II: Female observers will rate male therapists utilizing no disclosures with male clients as having a weaker working alliance versus male therapists utilizing similar disclosures with male clients.

Hypothesis III: Female observers will rate female therapists utilizing similar disclosures with female clients as having a stronger working alliance versus female therapists utilizing no self-disclosures with female clients.

Hypothesis IV: Female observers will rate female therapists utilizing similar disclosures with female clients as having a stronger working alliance versus female therapists utilizing dissimilar disclosures with female clients.

Hypothesis V: Male observers will rate female therapists utilizing similar disclosures with female clients as having a stronger working alliance versus female therapists utilizing no disclosures with female clients.

Research Question Two - Are there differences in observer ratings of the working alliance based on the three-way interaction of sex of the observer by sex of the therapist by sex of the client?

Hypothesis

Hypothesis VI: Male observers will rate female therapists utilizing similar disclosures with male clients as having a stronger working alliance versus male therapists utilizing similar disclosures with male clients.

Research Question Three – Are there differences in observer ratings of the working alliance based on the interaction of observer gender and type of disclosure?

Hypotheses

Hypothesis I vs. Hypothesis II

Hypothesis I: Male observers will rate male therapists utilizing no disclosures with male clients as having a stronger working alliance versus male therapists utilizing similar disclosures with male clients.

Hypothesis II: Female observers will rate male therapists utilizing no disclosures with male clients as having a weaker working alliance versus male therapists utilizing similar disclosures with male clients.

Hypotheses

Hypothesis VII vs. Hypothesis VIII

Hypothesis VII: Male observers will rate female recipients of similar disclosures with stronger working alliances versus male recipients of similar disclosures.

Hypothesis VIII: Female observers will rate female recipients of similar disclosures with weaker working alliances versus male recipients of similar disclosures.

CHAPTER THREE

Method

This chapter provides a description of the research methods. The first section describes the study's research participants, including a table that presents a breakdown by gender, academic classification, ethnicity, and college of enrollment. This is followed by a description of the materials the researcher created to collect data from participants. Information is also presented regarding the reliability and validity of the Working Alliance Inventory (WAI) (Horvath & Greenberg, 1994). A description of the procedures the researcher employed in collecting the data is also included. The chapter concludes with a listing of the explored hypotheses and a design of the study.

Participants

Participants included 357 undergraduate students from psychology, social work, human services, and civil engineering departments at two Midwestern universities. Demographic information on the participants is presented in Table 1. The mean age of the participants was 21.38 ($SD = 3.35$, ranging from 18 to 47). The mean age of the male participants was 21.19 ($SD = 2.17$), and the average age of the female participants was 21.50 ($SD = 3.94$). One (0.28%) participant was African American; 18 (5.04%) were Asian/Pacific Islander; 314 (87.96%) were Caucasian; 14 (3.92%) were Hispanic/Latino; 1 (.28%) was Native American/Alaska Native; 6 (1.68%) were Interracial/Mixed; and 3 (.84%) endorsed the ethnic category, "Other."

Table 1 Frequencies and Percentages for Demographic Characteristics of Participants

Characteristics	Total	Male	Female	% Total
Gender	357			
Male		142		39.80
Female			215	60.20
Class				
Freshman	61	25	36	17.10
Sophomore	60	26	34	16.90
Junior	135	50	85	37.90
Senior	99	40	59	27.50
Grad/Professional	2	1	1	0.60
Ethnicity				
African American	1	1		0.28
Asian/Pacific Islander	18	8	10	5.04
Caucasian	314	124	190	87.96
Hispanic/Latino	14	4	10	3.92
Native American/Alaska				
National	1	1		0.28
Interracial or Mixed	6	2	4	1.68
Other	3	2	1	0.84
College				
Agriculture	2	2		0.56
Architecture	2		2	0.56
Arts & Sciences	103	26	77	28.85
Business Administration	20	4	16	5.60
Education	69	26	43	19.33
Engineering	60	53	7	16.81
Human Ecology	8	2	6	2.24
Aviation/Technical	4	4		1.12
Graduate School	2	1	1	0.56
Other	87	24	63	24.37

Materials

Therapy Transcripts

The researcher created 12 therapy transcripts (see appendices A through L). All possessed an identical brief segment of hypothetical dialogue which occurred between a

college-aged counseling client and his or her therapist. Each of the transcripts included only one of three types of therapist self-disclosure (similar, dissimilar, and no therapist self-disclosure). This resulted in a transcript length by type of: similar disclosure (1,117 words), dissimilar disclosure (1,102 words), and no disclosure (1,127 words). The transcripts also differed by the gender composition of the client-therapist dyad, which resulted in four possible gender compositions (i.e., male therapist/female client, male therapist/male client, female therapist/female client, and female therapist/male client).

The therapist self-disclosure statements by type (i.e., similar, dissimilar, and no disclosure) were inserted at three identical locations across all 12 of the therapy transcripts. For the scripts involving the utilization of similar and dissimilar therapist disclosures, in all cases the therapist voiced the loss of their same sex parent. This was done to maintain consistency. For the no disclosure condition, three empathetic statements were substituted for the disclosures. Appendices A through L illustrate the script manipulations of the self-disclosure statements, identified by bold typeface.

However, the script manipulations given to participants in the study were not in bold typeface. The utilization of the script format is similar to what other researchers have used (Andersen & Anderson, 1985; Fox, Strum, & Walters, 1984; Nyman & Daugherty, 2001; Remer, Roffey, & Buckholtz, 1983; Watkins & Schneider, 1989).

Ten independent judges examined three therapy transcripts, one for each type of disclosure (similar, dissimilar, and no disclosure). These judges consisted of four female master's level clinicians, one master's level male clinician, two male doctoral level counselor educators, one female doctoral level counselor educator, one female psychologist, and one male psychologist. All were licensed clinicians in the state of

Nebraska and had a range of 5-10 years of clinical experience. Participant response forms were constructed for each of the transcripts. These response forms consisted of 5-point Likert-type rating scales participants used to indicate how similar and dissimilar the therapist's three self-disclosures were for each of the transcripts. A separate single-response rating form (yes/no), which was designed to ascertain whether the therapist's three empathetic statements were self-disclosures, was provided for the no disclosure condition. Clinician ratings were then calculated for their agreement on similarity, dissimilarity and no disclosure, using the median of the three disclosure ratings for each of the transcripts. These ratings by category and agreement were as follows: similar self-disclosure, 90% agreement; dissimilar self-disclosure, 86.66%; and no self-disclosure, 100%.

Instrument

Hill, Nutt, and Jackson (1994) found the *Working Alliance Inventory* (WAI) to be the most commonly used measure of the working alliance and of the therapeutic relationship. Horvath and Greenberg (1986) designed this instrument to measure the working alliance between a therapist and his or her client in relation to three areas Bordin (1979) proposed to be quintessential elements of the therapeutic alliance: presence of a therapeutic bond, agreement on therapeutic tasks, and agreement on the goals of therapy. Additionally, the WAI was designed to assess Bordin's (1980) theoretical definition of the working alliance: "what makes it possible for the patient to accept and follow treatment faithfully" (p. 2). The WAI was designed to assess the working alliance from client, therapist, and observer perspectives (Martin et al., 2000).

The development of the WAI was informed by a number of procedures. Goal, bond, and task components of the therapeutic alliance were established via an initial pool of 91 items (35 bond, 33 goal, and 23 task items) based on Bordin's (1976, 1980) descriptions of these three dimensions of the therapeutic relationship (Horvath & Greenberg, 1989). Once the initial pool of items was created, seven experts in the field of working-alliance research rated each item for its construct validity and relevancy to the working alliance, using a 5-point rating scale (1 = no relation, 5 = very related). Additionally, raters classified each of the evaluated items into one of the three alliance components (i.e., bonds, goals, and task). Items with an average relevance rating of 4 or less on the rating scale were eliminated from the initial item pool. Item elimination was also determined by establishing a percentage of agreement index (PA). Items which met a low percentage of agreement (defined as 70% or less) were rejected. A total of 21 items were rejected and 11 were edited.

To provide additional refinement of the item pool, 21 randomly selected registered psychologists from a local psychological association performed the identical rating steps as had the seven working alliance experts (Horvath & Greenberg, 1989). They eliminated 15 items considered irrelevant, which resulted in a remainder of 55 items which were then categorized into three referenced working alliance dimensions. Dimension clusters were then sorted by meaning through an open-ended sorting procedure, with meaning clusters being reduced in size by removal of those items with low ratings. This process continued until the desired number of 12 items was obtained for each dimension, resulting in a final pool of 36 items. Development of client and

counselor versions of the WAI resulted from the final item pool, each consisting of 36 items (12 for each of the alliance dimensions).

Horvath and Greenberg (1989) reported reliability estimates based on an item homogeneity index. This index was calculated from data derived from 29 graduate counseling psychology students involved in a peer-counseling task. Using data from this pilot testing, reliability estimates based on item homogeneity indices for each of the scales were determined to range from .68 to .87 for the counselor's version and from .85 to .88 for the client's version of the WAI. Cronbach's Alpha procedure produced reliability estimates of .93 for the client version of the WAI and .87 for the counselor's version. Reliability estimates for the subscales, as compared to the estimates for the overall instrument, were lower, ranging from .68 to .92 (Horvath & Greenberg, 1994). Interrater reliability was found to range from $r = .85$ to $r = .93$ for the WAI (Horvath & Greenberg, 1989).

The observer-rated version of the *Working Alliance Inventory* (WAI-O, Tichenor & Hill, 1989) was utilized for the purpose of this study, so as to examine the quality of the therapeutic alliance. Horvath and Bedi (2002) reported that an advantage of the observer version was that it can capture the working alliance from an objective point of view; however, one criticism of this instrument was that it only captured an inferential perspective of the client's experience. The WAI-O consisted of a 36-item inventory in which respondents rated statements that pertained to the perceived quality of the client/therapist relationship anchored on a seven-point rating scale (1 = never and 7 = always) (Martin et al., 2000). The instrument's three scales are each comprised of 12 of the instrument's 36 items. For each item, participants are asked to rate their perceptions

as to what each scale each item it attempting to capture, be it the mutually agreed upon goals of therapy, the tasks necessary to meet those goals, or the perceived bond between client and therapist. For instance, the first of the 36 items attempts to capture the perceived bond from the observer's point of view. For example, I believe *there is a sense of discomfort in the relationship*. An example of an item which attempts to capture mutual agreement on the goals of therapy includes, I believe *there is concern about the outcome of the sessions*. Lastly, an example of an item which attempts to capture from the observer's perspective the perceived mutual therapist/client task agreement includes, I believe *there is agreement about the steps taken to improve the client's situation*. Test-retest correlation, a more stringent measure of reliability, was found to be .92 for the observer rated version of the WAI (Martin et al., 2000).

Safran and Waller (1991) reported statistically significant ($p < .001$) correlations between scores on the California Psychotherapy Alliance Scales (CALPAS), a measure of the working alliance, and scores on the WAI subscales (Goal, $r = .84$; Task $r = .79$; and Bond, $r = .72$). Tichenor and Hill (1989) also explored this relationship in their comparison of six measures of the working alliance. Although existing measures had been designed to measure the working alliance from client and therapist perspectives, four measures were developed to enable the rating of the working alliance from the observer's perspective: the California Psychotherapy Alliance Scales (CALPAS, Marmar, Horowitz, Weiss, & Marzialim, 1987), the Penn Helping Alliance Rating Scale (PHARS, Luborsky, Crits-Cristoph, Alexander, Margolis, & Cohen, 1983; Alexander & Luborsky, 1987), the Vanderbilt Therapeutic Alliance Scale (VTAS, Hartley & Strupp, 1983), and the Working Alliance Inventory (WAI-O). Tichenor and Hill (1989) found the WAI-O to

be significantly correlated ($p < .05$) with the VTAS ($r = .71$), the CALPAS ($r = .82$), and the PHARS ($r = .84$). In addition, the CALPAS, VTAS, and the WAI-O were all found to be internally consistent, as indicated by the coefficient alphas: CALPAS = .90, Penn = .93, VTAS = .93, WAI-O = .98 (Tichenor & Hill, 1989). What is more, high-interrater reliability was found indicating the following intraclass correlations: CALPAS = .94, Penn = .71, VTAS = .74 and WAI-O = .92 (Tichenor & Hill, 1989). Consequently, the CALPAS, VTAS, and WAI-O all have high internal consistency, high interrater reliability, and a high degree of correlation with other measures of the working alliance (Tichenor & Hill, 1989). A distinct advantage of the WAI-O is that it is the only one of the above instruments that requires no rater training and is relatively straightforward to understand and use (Tichenor & Hill, 1989).

Procedure

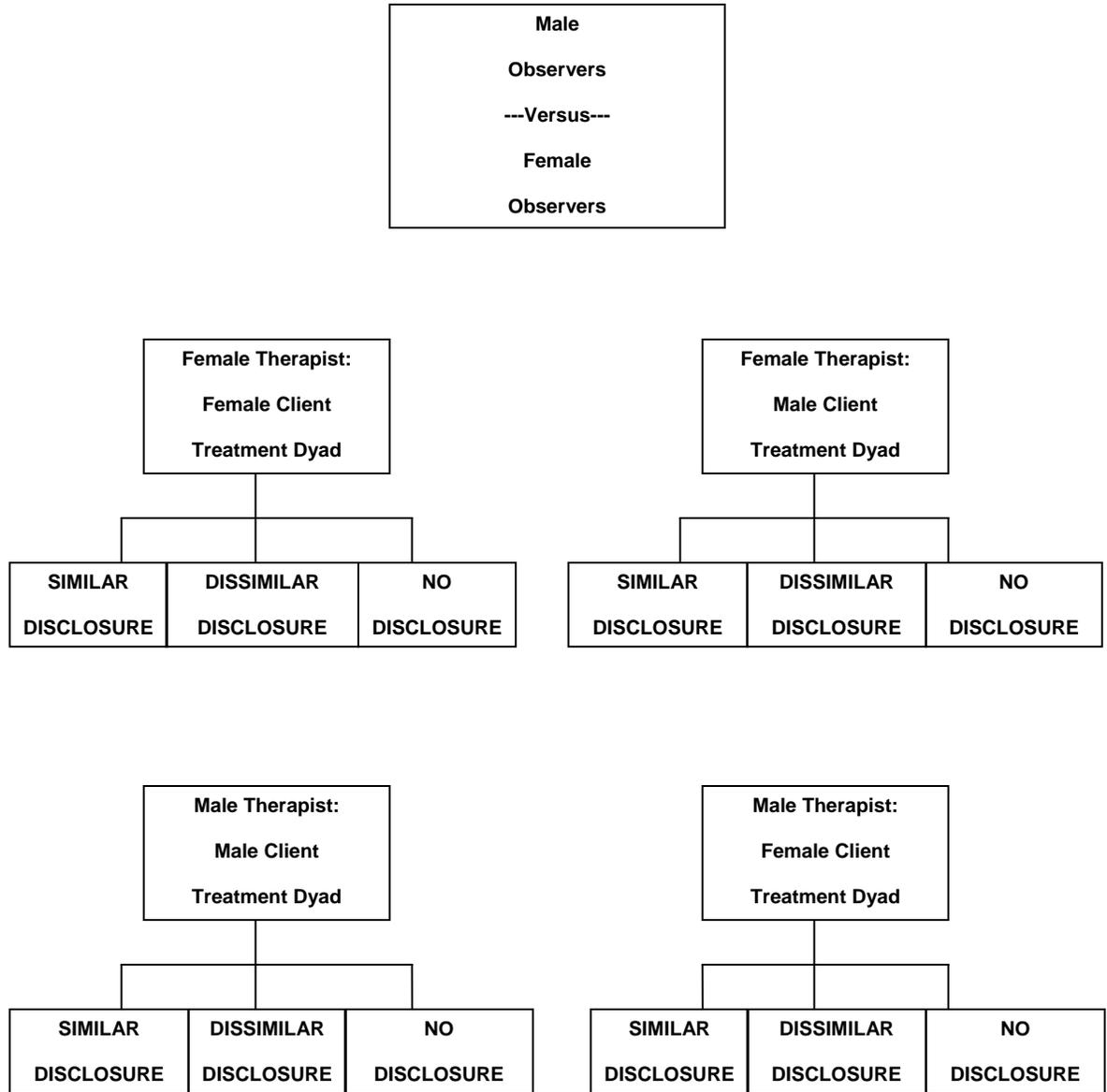
Following Institutional Review Board (IRB) approval, the departments of psychology, social work, civil engineering, and human services at two Midwestern Universities were contacted so as to secure permission for their students to participate. Student participation was voluntary. Participation was limited to students who had reached the age of consent (at least 19 years of age for one of the states and 18 years of age for the other).

The study's participants were stratified on the variable of gender and then assigned via a randomized blocks design to one of the 12 conditions: Male Therapist/Male Client/Similar Disclosure, Male Therapist/Male Client/Dissimilar Disclosure, Male Therapist/Male Client/No Disclosure, Male Therapist/Female Client/Similar Disclosure, Male Therapist/Female Client/Dissimilar Disclosure, Male

Therapist/Female Client/No Disclosure, Female Therapist/Female Client/Similar Disclosure, Female Therapist/Female Client/Dissimilar Disclosure, Female Therapist/Female Client/No Disclosure, Female Therapist/Male Client/Similar Disclosure, Female Therapist/Male Client/Dissimilar Disclosure, Female Therapist/Male Client/No Disclosure. As the participants first entered their respective classrooms, they found a research assistant who distributed a single research packet comprised of the following instruments in their exact order for completion: introduction statement, informed consent form, demographic form, therapy transcript, working alliance inventory, and debriefing form. Once all of the participants had arrived and received their assigned research packet, the research assistant read to them the introduction statement, which outlined the directions for the study (See appendix M).

The procedures requested the participants to read and sign the informed consent form (See appendix N), complete the provided demographic form (See Appendix O), read the assigned therapy transcript (See Appendix A-L), complete the WAI-O working alliance check, and read the research debriefing form (see Appendix Q), which informed the participants of the purposes for this research. Once all of the participants had completed these procedures, all research materials were then collected.

Figure 1 Research Design



Hypotheses

Hypothesis I: Male observers will rate male therapists utilizing no disclosure with male clients as having a stronger working alliance versus male therapists utilizing similar disclosures with male clients (Derlega et al., 1993; Fisher & Good, 1997; Johnson, 2005; Jourard, 1971; Levant, 1992; Napier, 1991; Petronio & Martin, 1986; Robertson, 2005; Scher, 1979, 2005; Youniss & Smollar, 1985).

Hypothesis II: Female observers will rate male therapists utilizing no disclosures with male clients as having a weaker working alliance versus male therapists utilizing similar disclosures with male clients (Dailey, 2004; Derlega et al., 1993; Caldwell & Peplau, 1982; Jourard, 1971; Myers, 2004; Peca-Baker & Friedlander, 1989).

Hypothesis III: Female observers will rate female therapists utilizing similar disclosures with female clients as having a stronger working alliance versus female therapists utilizing no self-disclosures with female clients (Bernstein et al., 1987, Blier et al., 1987; Boulware & Holmes, 1970; Caldwell & Peplau, 1982; Cash & Salzbach, 1978; Derlega et al., 1993; Jourard, 1971; Mann & Murphy, 1973; Nyman & Daugherty, 2001; Peca-Baker & Friedlander, 1989; Youniss & Smollar, 1985).

Hypothesis IV: Female observers will rate female therapists utilizing similar disclosures with female clients as having a stronger working alliance versus female therapists utilizing dissimilar disclosures with female clients (Bernstein et al., 1987; Blier et al., 1987; Boulware & Holmes, 1970; Caldwell & Peplau, 1982; Derlega et al. 1993; Howard et al., 1970; Jourard, 1971; Nyman & Daugherty, 2001; Peca-Baker & Friedlander, 1989; Youniss & Smollar, 1985).

Hypothesis V: Male observers will rate female therapists utilizing similar disclosures with female clients as having a stronger working alliance versus female

therapists utilizing no disclosures with female clients (Dailey, 2004; Johnson, 2005; Scher, 2005).

Hypothesis VI: Male observers will rate female therapists utilizing similar disclosures with male clients as having a stronger working alliance versus male therapists utilizing similar disclosures with male clients (Dailey, 2004; Dindia & Allen, 1992; Derlega et. al. 1993; Erickson, 1993; Johnson, 2005; Jourard, 1971; Scher, 2005).

Hypothesis VII: Male observers will rate female recipients of similar disclosures with stronger working alliances versus male recipients of similar disclosures (David & Brannon, 1976; Derlega et al., 1993; Fisher & Good, 1997; Good & Mintz, 2005; Johnson, 2005; Jourard, 1971; Levant, 1992; Napier, 1991; Scher, 1979; Scher, 2005; Youniss & Smollar, 1985).

Hypothesis VIII: Female observers will rate female recipients of similar disclosures with weaker working alliances versus male recipients of similar disclosures (Cash & Salzbach, 1978; Dailey, 2004; Mann & Murphy, 1975; Peca-Baker & Friedlander, 1989).

CHAPTER FOUR

Results

The purpose of this chapter is to present the results of the statistical analyses performed for this study. Two sections comprise this chapter. The first briefly introduces the statistical analyses, and the second examines the results of the statistical analyses. At a glance, these analyses consisted of separate four-way ANOVAs and MANOVAs calculated for the male and female observers, follow-up univariate ANOVAs calculated for male observers, and an analysis of simple effects calculated for female observers.

Statistical Analyses

Prior to testing the hypotheses, steps were taken to assess whether WAI-O scores were normally distributed. The histogram for the WAI-O total scores was slightly negatively skewed. The coefficient of skew was calculated to be .406, and the standard error of skew was .126. The z score for skewness (computed by dividing .406 by .126) was equal to -1.28, which was not significant at the .05 level. Therefore, it can be assumed that the distribution approximated normality. Also, z scores for the WAI-O revealed that only 4% of the cases had absolute values greater than or equal to 1.96, a percentage similar to what one would expect to find for a normal distribution. Therefore, all cases were retained in subsequent analyses, and no transformations were performed on the scores.

A 5 (data collection group) x 2 (therapist sex) x 2 (client sex) x 3 (disclosure type) ANOVA, which utilized Type III sum of squares, was calculated on WAI-O total scores. This analysis was calculated separately for both male and female observers. The data

collection group factor was included as a blocking variable and was not of interest in the current study. Means, standard deviations and sample sizes are listed separately for these factors for both male and female observers in Tables 2 and 3.

Table 2 WAI-O Means and Standard Deviations by Therapist Sex, Client Sex, and Disclosure Type (Male Observers)

<u>Disclosure</u>	Male Observers											
	MTH/MCL			FTH/FCL			MTH/FCL			FTH/MCL		
	<u>M</u>	<u>SD</u>	<u>n</u>	<u>M</u>	<u>SD</u>	<u>n</u>	<u>M</u>	<u>SD</u>	<u>n</u>	<u>M</u>	<u>SD</u>	<u>n</u>
Similar	184.36	29.48	14	180.64	21.50	14	183.62	30.98	13	175.06	24.11	16
Dissimilar	188.63	29.39	8	176.00	23.95	12	182.44	25.02	9	172.67	25.46	12
No Disclosure	174.55	23.03	11	186.73	28.82	11	177.83	20.88	12	200.90	30.81	10

Note. MTH/MCL = male therapist/male client; FTH/FCL = female therapist/female client; MTH/FCL = male therapist/female client; FTH/MCL = female therapist/male client.

Table 3 WAI-O Means and Standard Deviations by Therapist Sex, Client Sex, and Disclosure Type (Female Observers)

<u>Disclosure</u>	Female Observers											
	MTH/MCL			FTH/FCL			MTH/FCL			FTH/MCL		
	<u>M</u>	<u>SD</u>	<u>n</u>	<u>M</u>	<u>SD</u>	<u>n</u>	<u>M</u>	<u>SD</u>	<u>n</u>	<u>M</u>	<u>SD</u>	<u>n</u>
Similar	197.71	20.91	21	191.33	23.58	18	183.48	18.49	21	197.67	22.22	21
Dissimilar	186.76	27.70	17	194.79	26.42	19	184.81	27.79	21	179.58	31.65	19
No Disclosure	194.94	29.70	16	188.73	14.02	15	194.43	25.35	14	187.00	23.11	13

Note. MTH/MCL = male therapist/male client; FTH/FCL = female therapist/female

client; MTH/FCL = male therapist/female client; FTH/MCL = female therapist/male client.

Results of the four-way ANOVA, conducted to test hypotheses related to the WAI-O total scores, are displayed in Tables 4 and 5. As indicated in Table 4, a significant main effect for the data collection group factor was found for the male observers $F(4, 100) = 3.27, p < .05, \eta^2 = .116$. Consequently, including the data collection group as a blocking variable was beneficial. However, this factor was not of interest, and therefore no follow-up analyses were performed. No significant main effects or interactions were found for either the male or the female observers on the factors of sex of client, sex of therapist, and type of disclosure (see Tables 4 and 5).

Table 4 Analysis of Variance Results for Main Effects and Interaction Effects of Data Collection Group, Sex of Therapist, Sex of Client, and Type of Disclosure on Male Observer Ratings of the Working Alliance Inventory (WAI-O)

<u>Source</u>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>Sig.</i>
Main effect of Therapist Sex (TH SEX)	1	689.72	1.02	.315
Main effect of Client Sex (CL SEX)	1	945.35	1.40	.240
Main effect of Disclosure (DISCL)	2	667.00	0.98	.377
Main effect of Group (GROUP)	4	2212.38	3.27*	.015
TH SEX * CL SEX	1	390.91	0.58	.449
TH SEX * DISCL	2	653.08	0.96	.385
CL SEX * DISCL	2	662.05	0.98	.380
TH SEX * CL SEX * DISCL	2	82.37	0.12	.886
TH SEX * GROUP	3	240.77	0.36	.785
CL SEX * GROUP	4	874.13	1.29	.279
TH SEX * CL SEX * GROUP	2	489.51	0.72	.488
DISCL * GROUP	4	323.92	0.48	.752
TH SEX * DISCL * GROUP	4	157.59	0.23	.919
CL SEX * DISCL * GROUP	4	771.17	1.14	.343
TH SEX * CL SEX * DISCL * GROUP	3	434.06	0.64	.591
ERROR	100	677.62		
TOTAL				

* $p < .05$.

Note. TH SEX = therapist sex; CL SEX = client sex; DISCL = disclosure.

Table 5 Analysis of Variance Results for Main Effects and Interaction Effects of Data Collection Group, Sex of Therapist, Sex of Client, and Type of Disclosure on Female Participant Ratings of the Working Alliance Inventory (WAI-O)

<u>Source</u>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>Sig.</i>
Main effect of observer gender (TH SEX)	1	9.79	0.02	.90
Main effect of therapist gender (CL SEX)	1	1946.20	3.31	.07
Main effect of disclosure type (DISCL)	2	368.90	0.63	.54
Main effect by group (GROUP)	4	1205.23	2.05	.09
TH SEX * CL SEX	1	476.62	0.81	.37
TH SEX * DISCL	2	195.76	0.33	.72
CL SEX * DISCL	2	1492.75	2.54	.08
TH SEX * CL SEX * DISCL	2	679.04	1.16	.32
TH SEX * GROUP	4	1202.19	2.05	.09
CL SEX * GROUP	4	1196.80	2.04	.09
TH SEX * CL SEX * GROUP	2	620.09	1.06	.35
DISCL * GROUP	7	511.03	0.87	.53
TH SEX * DISCL * GROUP	4	449.79	0.77	.55
CL SEX * DISCL * GROUP	5	244.38	0.42	.84
TH SEX * CL SEX * DISCL * GROUP	5	300.26	0.51	.73
ERROR	167	587.79		
TOTAL				

* $p < .05$.

Note. TH SEX = therapist sex; CL SEX = client sex; DISCL = disclosure.

Additional Hypotheses Tested

Although not included in the initial hypotheses, tests were conducted to examine possible main effects and interactions related to the three subscales of the WAI-O. A four-way MANOVA was performed, utilizing the same four factors reported previously for both the male and female observers. Table 6 displays the means, standard deviations, and sample sizes for the male observers on the three dependent measures: Task, Bond, and Goal subscales. Correlations between the three subscales were statistically significant ($p < .01$): Task with Bond ($r = .83$), Task with Goal ($r = .83$), and Bond with Goal ($r = .78$). The magnitude of these correlations may call into question the orthogonality of the subscales as measures of their intended constructs.

Table 6 WAI-O Bond, Task, and Goal Component Means and Standard Deviations by Sex of Therapist, Sex of Client, and Type of Disclosure – Male Observers

Bond												
Disclosure	MTH/MCL			FTH/FCL			MTH/FCL			FTH/MCL		
	<i>M</i>	<i>SD</i>	<i>n</i>									
Similar	61.14	12.05	14	61.36	7.16	14	62.62	10.60	13	59.38	8.07	16
Dissimilar	64.00	11.56	8	58.42	10.35	12	62.11	9.71	9	56.75	10.95	12
No Disclosure	57.64	7.51	11	63.27	12.46	11	59.83	7.30	12	66.60	11.65	10

Task												
Disclosure	MTH/MCL			FTH/FCL			MTH/FCL			FTH/MCL		
	<i>M</i>	<i>SD</i>	<i>n</i>									
Similar	62.71	10.22	14	61.71	7.87	14	62.54	11.70	13	60.75	10.10	16
Dissimilar	63.00	12.19	8	61.17	9.01	12	62.22	10.12	9	60.25	8.18	12
No Disclosure	59.09	8.64	11	63.18	9.14	11	60.50	7.88	12	69.20	10.51	10

Goal												
Disclosure	MTH/MCL			FTH/FCL			MTH/FCL			FTH/MCL		
	<i>M</i>	<i>SD</i>	<i>n</i>									
Similar	60.50	8.39	14	57.57	7.59	14	58.46	9.55	13	54.94	7.95	16
Dissimilar	61.63	8.31	8	56.42	7.49	12	58.11	8.71	9	55.67	8.79	12
No Disclosure	57.82	8.38	11	60.27	8.72	11	57.50	8.24	12	65.10	9.74	10

Note. MTH/MCL = male therapist/male client; FTH/FCL = female therapist/female client; MTH/FCL = male therapist/female client; FTH/MCL = female therapist/male client.

With respect to male observers, a significant multivariate effect was found for Group, *Wilkes's Lambda* (12, 259.575) = .779, $p < .05$ (see Table 7). Follow-up univariate ANOVAs indicated the main effect for Group resided only in the Bond subscale, $F(4, 100) = 4.858, p < .05, \eta^2 = .163$. No additional analyses were made on this variable

because it was not of research interest. In addition, there was a significant multivariate effect for the three-way interaction of Sex of the Therapist x Disclosure x Group, *Wilkes's Lambda* (12, 259.575) = .792, $p < .05$. However, univariate F 's were not statistically significant for any of the subscales. There were no other significant main effects or interactions (see table 7).

Table 7 Multivariate and Univariate Analyses of Variance for Working Alliance Scales (WAI-O) – Male Observers

Source	<u>Multivariate</u>			<u>Univariate</u>								
				Bond			Task			Goal		
	df	F	Partial Eta Squared	df	F	Partial Eta Squared	df	F	Partial Eta Squared	df	F	Partial Eta Squared
TH SEX	3	0.98	0.03	1	0.75	0.01	1	0.39	0.00	1	1.97	0.02
CL SEX	3	1.86	0.05	1	0.19	0.00	1	1.26	0.01	1	3.43	0.03
DISCL	6	0.86	0.03	2	1.56	0.03	2	0.44	0.01	2	0.89	0.02
GROUP	12	2.15	0.08	4	4.86	0.16*	4	2.08	0.08	4	2.20	0.08
TH SEX * CLSEX	3	2.43	0.07	1	0.13	0.00	1	0.06	0.00	1	2.81	0.03
TH SEX * DISCL	6	0.55	0.02	2	0.41	0.02	2	0.30	0.02	2	0.45	0.01
CL SEX * DISCL	6	0.69	0.02	2	0.89	0.02	2	1.24	0.02	2	0.45	0.01
THSEX * CLSEX * DISCL	6	0.35	0.01	2	0.01	0.00	2	0.24	0.01	2	0.32	0.01
TH SEX * GROUP	9	0.80	0.02	3	0.59	0.02	3	0.29	0.01	3	0.44	0.01
CL SEX * GROUP	12	1.61	0.06	4	0.47	0.02	4	1.27	0.05	4	2.53	0.09
TH SEX * CLSEX * GROUP	6	0.68	0.02	2	0.59	0.01	2	0.31	0.01	2	1.30	0.03
DISCL * GROUP	12	0.79	0.03	4	0.90	0.04	4	0.49	0.02	4	0.27	0.01
TH SEX * DISCL * GROUP	12	1.99	0.08	4	0.70	0.03	4	0.05	0.00	4	1.12	0.04
CL SEX * DISCL * GROUP	12	1.13	0.04	4	1.54	0.06	4	0.51	0.02	4	1.40	0.05
TH SEX * CLSEX * DISCL * GROUF	9	0.49	0.02	3	0.44	0.01	3	0.86	0.03	3	0.55	0.02
ERROR												
TOTAL												

**p* < .05.

Note. TH SEX = therapist sex; CL SEX = client sex; DISCL = disclosure.

A four-way MANOVA was also calculated for the female observers. Table 8 displays the means, standard deviations, and sample sizes for the female observers on the Bond, Task, and Goal subscales.

Table 8 WAI-O Bond, Task, and Goal Component Means and Standard Deviations for Observer Sex, Sex of Therapist, Sex of Client, and Type of Disclosure – Female Observers

	Bond											
	MTH/MCL			FTH/FCL			MTH/FCL			FTH/MCL		
	<u>M</u>	<u>SD</u>	<u>n</u>									
Disclosure												
Similar	67.62	8.92	21	64.94	6.92	18	61.00	7.04	21	67.24	7.66	21
Dissimilar	63.06	8.96	17	66.21	9.30	19	61.00	9.24	21	60.05	11.65	19
No Disclosure	64.81	10.11	16	63.00	5.77	15	66.43	9.50	14	61.00	8.09	13
	Task											
	MTH/MCL			FTH/FCL			MTH/FCL			FTH/MCL		
<u>Disclosure</u>	<u>M</u>	<u>SD</u>	<u>n</u>									
Similar	67.48	6.57	21	66.00	8.15	18	63.33	5.94	21	67.43	7.83	21
Dissimilar	63.71	7.71	17	65.26	8.89	19	62.57	9.35	21	61.47	11.14	19
No Disclosure	66.94	9.64	16	64.73	5.92	15	66.00	8.60	14	65.69	8.38	13
	Goal											
	MTH/MCL			FTH/FCL			MTH/FCL			FTH/MCL		
<u>Disclosure</u>	<u>M</u>	<u>SD</u>	<u>n</u>									
Similar	62.62	7.51	21	60.39	10.11	18	59.14	7.54	21	63.00	7.66	21
Dissimilar	60.00	12.77	17	63.32	9.56	19	61.24	10.66	21	58.05	10.75	19
No Disclosure	63.19	11.49	16	61.00	4.66	15	62.00	9.05	14	60.31	7.77	13

Note. MTH/MCL = male therapist/male client; FTH/FCL = female therapist/female client; MTH/FCL = male therapist/female client; FTH/MCL = female therapist/male client.

For female observers, the four-way MANOVA revealed a significant effect for the Client Sex x Disclosure interaction ($\lambda^2 = .043, p < .023$) (see Table 9). However, this was only found for the *Bond* subscale $F(2, 167) = 4.298, p > .05, \eta^2 = .049$.

Table 9 Multivariate and Univariate Analyses of Variance for Working Alliance Subscales (WAI-O) – Female Observers

Source	<u>Multivariate</u>			<u>Univariate</u>								
				Bond			Task			Goal		
	df	<i>F</i>	Partial Eta Squared	df	<i>F</i>	Partial Eta Squared	df	<i>F</i>	Partial Eta Squared	df	<i>F</i>	Partial Eta Squared
TH SEX	3	0.09	0	1	0.004	0	1	0.015	0	1	0.084	0.001
CL SEX	3	1.34	0.02	1	1.99	0.01	1	2.70	0.02	1	4.03	0.02
DISCL	6	1.78	0.03	2	1.33	0.02	2	1.00	0.01	2	0.16	0.00
GROUP	12	1.29	0.03	4	1.25	0.03	4	2.23	0.05	4	2.25	0.05
TH SEX * CLSEX	3	1.18	0.02	1	2.15	0.01	1	0.42	0.00	1	0.18	0.00
TH SEX * DISCL	6	0.60	0.01	2	0.75	0.01	2	0.14	0.00	2	0.30	0.00
CL SEX * DISCL	6	2.49*	0.04	2	4.30*	0.05	2	1.14	0.01	2	1.95	0.02
THSEX * CLSEX * DISCL	6	0.95	0.02	2	1.61	0.02	2	1.09	0.01	2	0.66	0.01
TH SEX * GROUP	12	0.95	0.02	4	1.62	0.04	4	2.40	0.05	4	1.54	0.04
CL SEX * GROUP	12	1.06	0.03	4	1.69	0.04	4	2.12	0.05	4	1.81	0.04
TH SEX * CLSEX * GROUP	6	0.49	0.01	2	1.36	0.02	2	0.81	0.01	2	0.68	0.01
DISCL * GROUP	21	1.25	0.05	7	0.68	0.03	7	1.36	0.05	7	0.72	0.03
TH SEX * DISCL * GROUP	12	0.61	0.01	4	1.01	0.02	4	0.55	0.01	4	0.63	0.02
CL SEX * DISCL * GROUP	15	0.97	0.03	5	0.83	0.02	5	0.48	0.01	5	0.33	0.01
TH SEX * CLSEX * DISCL * GROUF	12	1.01	0.02	4	0.63	0.02	4	0.33	0.01	4	0.80	0.02
ERROR												
TOTAL												

**p* < .05.

Note. TH SEX = therapist sex; CL SEX = client sex; DISCL = disclosure.

An analysis of simple effects was conducted on the Bond subscale to pinpoint the exact nature of the Client Sex x Disclosure interaction. For male clients, female observers provided stronger bond ratings for similar disclosure than for the dissimilar disclosure, *F*

(2, 209) = 3.354, $p > .05$, $\eta^2 = .031$ (see Table 10). However, when the client was female, no significant differences were found for female observers as a result of changes in the type of disclosure. In addition, female observers rated male clients with a stronger bond than female clients, but only in the similar disclosure condition. Consistent with prior research, the ambiguity of female preferences either for or against therapist disclosure and with intimacy in the female context appear to coincide with the above findings.

To test possible differences due to observer sex, a 2 (observer sex) x 2 (therapist sex) x 2 (client sex) x 3 (disclosure type) ANOVA was conducted on WAI-O total scores. No significant main effects or interactions were found. A 2 x 2 x 2 x 3 MANOVA was also performed on WAI-O subscales. The only significant finding was for the main effect of observer sex ($\lambda^2 = .961$; $p < .002$). Univariate follow-ups revealed differences on Task, $F(1, 359) = 12.35$, $p > .001$, $\eta^2 = .038$; and Bond, $F(1, 359) = 14.15$, $p > .001$, $\eta^2 = .033$. On the Task subscale, female observers ($M = 65.08$, $SD = 8.34$) scored higher than male observers ($M = 61.54$, $SD = 9.61$); on the Bond subscale, female observers ($M = 63.98$, $SD = 8.94$) also scored higher than male observers ($M = 60.41$, $SD = 9.96$).

Table 10 Means and Standard Deviations for Client Sex by Disclosure for Female Observers

Means and Standard Deviations for Client Sex by Disclosure for

Female Observers

Client Sex	Disclosure Type	<i>M</i>	<i>SD</i>	<i>n</i>
Female	Dissimilar	63.48	9.52	40
	No Disclosure	64.66	7.85	29
	Similar	62.82	7.17	39
	Total	63.56	8.24	108
Male	Dissimilar	61.47	10.43	36
	No Disclosure	63.10	9.31	29
	Similar	67.43	8.21	42
	Total	64.25	9.59	107
Total	Dissimilar	62.53	9.95	76
	No disclosure	63.88	8.57	58
	Similar	65.21	8.02	81
	Total	63.90	8.99	215

Summary

The results of the statistical analyses revealed the following. First, no main effects or interactions were found on the WAI-O total scale when male and female observers were analyzed separately. Second, no main effects or interaction effects were found for male observers on the WAI-O subscales. Third, female observers perceived stronger client-therapist bond for similar than dissimilar disclosures with male clients. Fourth, female observers rated male clients with a stronger bond than female clients on the Bond subscale, but only in the similar disclosure condition. Fifth, no main effects or interactions were found on WAI-O total scale when male and female observers were analyzed together. Sixth, a main effect was observed for observer sex on the Task and Bond subscales. Specifically, on both subscales, female observers perceived stronger client-therapist agreement than did male observers.

CHAPTER FIVE

Discussion

The first section of this chapter briefly presents the central findings for this study that pertain to the research questions and hypotheses. The second expands on those findings and provides a summary of the results for the hypotheses and research questions, along with possible explanations of how the research findings fit into the context of prior research. The third section discusses the implications of the findings, and the fourth outlines the limitations of the study. The final section addresses suggestions for future research.

Central Findings

This study explored influences of the student observer's gender, type of therapist disclosure utilized, gender composition of the therapist/client dyad, and the interaction of these factors on observer perceptions of the overall measure of the working alliance. Expectations were that, in accordance with the proposed hypotheses and research questions, these factors would differentiate observers on their ratings of the working alliance; however, primary analyses found these factors to lack a significant effect. However, additional analysis, unrelated to the proposed hypotheses and research questions, found significance on the bond subscale of the working alliance. Specifically, female observers had more favorable impressions of the bond between the therapist and the client when this involved male clients who were recipients of similar versus dissimilar therapist disclosure. Moreover, these same observers also had favorable impressions of the bond, specifically when this involved male versus female clients; however, this was only in cases where these clients were recipients of similar therapist disclosure. Lastly,

female observers provided stronger ratings on the bond and task subscales of the working alliance. These findings are explained later in the chapter.

Summary of the Results for the Research Questions and Hypotheses

The objectives of this section are fourfold. One objective of this section is to discuss the results of the statistical analyses so as to answer each of the stated research questions. A second objective is to discuss the findings in the context of prior research, whereas the third is to present supportive evidence for each of the stated hypotheses. The fourth and final objective for this section is to present contradictory evidence for each of the stated hypotheses.

Research Question One

The first research question for this study was: Are there differences in observer ratings of the working alliance based on the type of the therapist's disclosure? This question was explored via manipulations in the type of the therapist's disclosure: similar, dissimilar, and no disclosure type. The results of these manipulations indicated there were no significant differences on observer ratings of the working alliance between similar, dissimilar, and no therapist disclosure. Although significant differences were expected, as outlined and proposed in the hypotheses, observer perceptions of the working alliance were not significantly different due to type of therapist disclosure.

Hypothesis I

It was proposed male observers would rate male therapists utilizing no disclosure with male clients as having stronger working alliances versus male therapists utilizing similar disclosure with male clients. This was proposed for several reasons including the following: intimacy has historically been a difficult issue for men (Scher, 2005); men have been found to fear one another (Scher, 1979b), to be emotionally unexpressive (Jourard, 1971), to possess role

expectations of toughness (Jourard, 1971), and to struggle with words for feelings (Fisher & Good, 1997; Levant, 1992; Napier, 1991); and therapists recommend that male therapists restrain affection, utilize patience, and proceed skillfully when in their therapy with male therapists (Robertson, 2005; Scher, 2005). However, the results of current study provided no support for this hypothesis.

One might consider the prior evidence which found some men to have favorable impressions of similar and congruent disclosures (Giannandrea & Murphy, 1973; Nyman & Daugherty, 2001). Moreover, Giannandrea and Murphy (1973) found similar disclosures employed at a moderate rate, of three to six, over a course of 20 minutes resulted in a greater return rate of male participants to a male interviewer compared to few (zero to two) or many (six to twelve) similar disclosures. However, Giannandrea and Murphy (1973) questioned whether it was the similarity or the frequency of the disclosures that resulted in the positive results. Moreover, Nyman and Daugherty's (2001) examination of congruent versus incongruent disclosures found male participants to assign more favorable ratings to disclosures of a congruent or similar nature in their study. Consequently, there is some indication that males do not always have unfavorable impressions of similar or congruent disclosures, a possible explanation as to why the male observers did not assign stronger working alliance ratings to the no therapist disclosure condition versus the similar disclosure condition.

Hypothesis II

It was proposed female observers would assign weaker working alliance ratings to male therapists utilizing no disclosure with male clients versus male therapists utilizing similar disclosure with male clients. Significant differences were expected because past research indicated women possess gender role expectations of nurturance and comfort (Jourard, 1971),

pursue communal and social-emotional gender goals (Derlega, 1993), and desire intimacy in same-sex relationships (Caldwell & Peplau, 1982). Moreover, past research indicated women disclose more regarding personal and sensitive topics, express more feelings, and are more emotionally supportive. However, these findings only pertained to the context of communication between women (Derlega et al., 1993), whereas the current hypothesis explored female observer impressions of disclosure between men. However, no evidence was found in the current study to this hypothesis.

In examining prior research, none could be found regarding female observer impressions of male therapists who disclosed to male clients. Female observer disclosure impressions were considered in the context of other scenarios. Inspection of Dailey's (2004) research found some women to have concerns about the impact of their personal disclosures upon their female therapists, whereas Peca-Baker and Friedlander (1989) found varied disclosure types to have no effect on female observer ratings. Consequently, both of these studies seem to indicate the absence of positive female observer impressions for the act of self-disclosure (Dailey, 2004; Peca-Baker & Friedlander, 1989). However, these findings only pertained to the context of the female therapist/female client relationship. Perhaps more closely related was Myers' (2004) study investigating female recipient impressions of male-therapist disclosure; however, this was only in regard to the context of female impressions as recipients of the disclosure, not their impressions as observers of male recipients of male therapist disclosures. Nonetheless, Myers (2004) found positive results, but only when the female recipients were in a therapist-client relationship characterized as having a strong pre-established working alliance. Lastly, research that explored the strength of one's gender role identity and its relationship to self-disclosure was also explored. According to Derlega et al. (1993), strength of internalized gender identity could

affect one's utilization of self-disclosure. In fact, those purported to have strongly internalized gender role identities might allow the factor of gender to have a more intensified effect on self-disclosure in their close relationships (Derlega et al., 1993). Consequently, one might question how internalized were the gender role identities of the female observers, and did this have an affect on their ratings.

Hypothesis III

It was proposed female observers would rate female therapists utilizing similar disclosures with female clients as having stronger working alliances versus female therapists utilizing no disclosure with female clients. Heightened working alliance ratings for the similar disclosures were expected because women, when they talk to other women, disclose more on personal and sensitive topics, express more feelings, and are more emotionally supportive of one another (Derlega et al., 1993). Moreover, past research found women preferred female counselors in matters of personal concern (Bernstein et al., 1987; Blier et al., 1987; Boulware & Holmes, 1970), whereas other researchers found female recipients responded favorably to similar therapist disclosures (Mann & Murphy, 1975; Nyman & Daugherty, 2001; Peca-Baker & Friedlander, 1989).

Contrary to expectations, there were no significant differences between female observer ratings of the working alliance for similar and no disclosure conditions. One explanation for the null effect is prior evidence women do not always have positive evaluations of therapist disclosure (Dailey, 2004; Myers, 2004). In fact, Dailey (2004) reported female clients who worked with female therapists expressed great concern about the impact of their disclosures upon the feelings of their female therapists. In addition, Peca-Baker and Friedlander (1989) found no

differences in female participants' perceptions of female therapists who disclosed personal material similar to the client's problem, compared to therapists who provided no disclosure at all.

Hypothesis IV

The fourth hypothesis proposed female observers would rate female therapists utilizing similar disclosure with female clients as having stronger working alliances versus female therapists utilizing dissimilar disclosure with female clients. This hypothesis was put forth because female therapists prefer female clients in matters of "personal concern" (Bernstein et al., 1987; Blier et al., 1987; Boulware & Holmes, 1970), and because congruent disclosures lead to more favorable female participant ratings compared to disclosures of an incongruent nature (Nyman & Daugherty, 2001). In addition, it was expected the similar disclosures would generate stronger working alliance ratings because past research indicated women have favorable reactions to similar disclosure; however, this was only in the context of a strong working alliance (Myers, 2004). Moreover, examinations of same-sex studies found women to prefer intimate communication in same-sex relationships (Caldwell & Peplau, 1982; Youniss & Smollar, 1985). Furthermore, women disclose more on personal and sensitive topics, express more feelings, and are more emotionally sensitive with one another (Derlega et al., 1993). Subsequently, there was some evidence to suggest women would assign stronger working alliance ratings to similar than dissimilar disclosures.

Contrary to the proposed hypothesis, there were no significant differences between female observer working alliance ratings for the similar and dissimilar disclosures. Examined in the context of prior research, the null effect was not unlike that of other researchers who also did not find significant differences between the participant ratings of similar and dissimilar therapist disclosure (Mann & Murphy, 1975; Peca-Baker & Friedlander, 1989). In fact, Peca-Baker and

Friedlander (1989) found no significant differences in female participant ratings of therapist attractiveness, trustworthiness, and empathy in comparisons between similar and dissimilar therapist disclosures. However, post-experimental structured interviews indicated the sender's utilization of disclosure had a positive impact, as did the similarity of the information, upon the participants' experience (Peca-Baker & Friedlander, 1989).

Past research also examined therapist disclosure in the context of the strength of the working alliance (Myers, 2004). Myers (2004) found a positive relationship between therapist disclosure and the working alliance; however, this was only in the context of a strong working alliance (Myers, 2004). Consequently, one might ask, what were the current observers' initial perceptions of the strength of the working alliance? Also did these perceptions influence the observers' ratings of the working alliance? Perhaps if the female observers' initial perceptions of the initial working alliance were weak, they may have felt threatened by the personal nature of the similar disclosures. Additionally, this might have carried over to the dissimilar disclosures, because they were also personal.

Hypothesis V

The fifth and final hypothesis for the above research question proposed male observers would rate female therapists utilizing similar disclosures with female clients as having stronger working alliances than female therapists utilizing no disclosures with female clients. This hypothesis was proposed because past research had found male clients utilize female therapists more so than male therapists, and because men rate female therapists as more knowledgeable about relationship issues, safer, and less likely to taunt or tease them compared to male therapists (Johnson, 2005). Additionally, some men perceive male relationships as too competitive

(Johnson, 2005), and they are less concerned about the impact of their disclosures concerning intimate material with female therapists (Dailey, 2004).

Consequently, it was expected that the male observers would assign stronger working alliance ratings to female therapists utilizing similar disclosures with female clients versus female therapists utilizing no disclosure with female clients. However, there were no significant differences on participant ratings for these two conditions. Perhaps there were no differences for either of the conditions because men--across-the-board--have frequently struggled with intimacy (Scher, 2005), with words for feelings (Fisher & Good, 1997; Levant, 1992, Napier, 1991), and have demonstrated less of an interest in self-disclosure relative to women (Derlega et al., 1993). Moreover, perhaps past research which found men avoid things feminine (e.g., expression of feelings and the position of vulnerability) might also explain the lack of significant findings (David & Brannon, 1976).

Research Question Two

The second research question for this study was: Are there differences in observer ratings of the working alliance based on the therapist/client gender dyad? This question was explored as delineated in the hypothesis below. Results for this investigation revealed an absence of significant differences on observer ratings of the working alliance when observers were exposed to unique gender arrangements of the therapy dyad and similar, dissimilar, and no therapist disclosures.

Hypothesis VI

It was proposed male observers would assign stronger working alliance ratings to female therapists utilizing similar disclosures with male clients versus male therapists utilizing similar disclosures with male clients. This finding was expected because researchers found male clients

to frequent female therapists more than male therapists and to hold to expectations female therapists were more knowledgeable about relationship issues than male therapists (Johnson, 2005). Moreover, it was anticipated male observers would assign stronger working alliance ratings to female therapists, because past research indicated male clients feared that male therapists would taunt and tease them for past failures, and because some men believe their expression of feelings would be less shameful in the context of the female therapist (Johnson, 2005). Finally, significant differences were anticipated because some researchers had found male clients seek out female therapists due to perceptions male relationships are too competitive (Johnson, 2005; Scher, 2005); and because researchers had found women possess gender role expectations of nurturance and comfort (Jourard, 1971).

Contrary to the proposed hypothesis, there was no support in the current study for this hypothesis. Perhaps the inability to find significance is related to the finding some male clients are ambivalent or are generally unaware of their emotions (Fischer & Good, 1997; Levant, 1992; Napier, 1991). What is more, perhaps the value one's gender places on self-disclosure might have also had an influence, because past research found male clients were less interested in self-disclosure than were female clients (Derlega et al., 1993); consequently, the gender of the discloser may have been irrelevant.

Research Question Three

The third and final research question was: Are there differences in observer ratings of working alliance based on the interaction of various combinations of observer, therapist, and client gender-dyads and disclosure type? To answer this question, several of the previously stated hypotheses were considered and examined in the primary analysis. Separate statistical analyses conducted for male and female observers found no significant differences due to the

gender of the observer, gender composition of the therapist/client therapy dyad, and type of the therapist's disclosure.

In the primary analysis designed to investigate observer gender and disclosure type effects on the working alliance, several hypotheses which are listed below were examined. Hypothesis I and II posited male and female observers would assign significantly different alliance ratings to the constructed therapy scenarios due to their gender and type of the therapist's disclosure. However, there were no significant differences between female and male observer ratings of the working alliance as a result of the observer's gender and the type of therapist disclosure.

Male and female observers may not have differed on their ratings of the working alliance due to a number of reasons. One reason is perhaps the male observers did not see the similar disclosures as detrimental, consequently lessening the ability to promote a greater contrast between male and female observer perceptions. In fact, some studies have found men to have positive impressions of similar therapist disclosures (Giannandrea & Murphy, 1973; Nyman & Daugherty, 2001). Although these studies only utilized male participants, only one study identified the utilization of a male discloser (Giannandrea & Murphy, 1973; Nyman & Daugherty, 2001). In addition, it was questioned in the former study whether it was the similarity of the disclosures or the number of disclosures which resulted in the positive findings. A second possible reason as to why the expected findings were not found is because the female observers did not see the male therapist's similar disclosures as helpful. In fact, in a recent study conducted by Myers (2004), female respondents struggled with male therapist disclosure; however, this was only in the case of a weak therapist/client working alliance. In terms of this

study, there is no way to determine whether strength of the working alliance was a factor because it was not ascertained beforehand.

Hypotheses VII and VIII anticipated male and female observers would assign significantly different working alliance ratings due to the gender of the observer and the recipient of the disclosure. Hypothesis VII proposed male observers would assign stronger working alliance ratings to female recipients of similar disclosures versus male recipients of similar disclosures. This proposal was made for a number of reasons, including: masculinity injunctions, gender expectancies, gender goals, alexithemia or man's difficulty with describing their feelings, male ambivalence towards emotional transparency, gender role expectations, and research suggesting men utilize female therapists more so than male therapists (David & Brannon, 1976; Derlega et al., 1993; Fisher & Good, 1997; Good & Mintz, 2005; Johnson, 2005; Jourard, 1971; Levant, 1992; Napier, 1991; Scher, 1979; 2005; Youniss & Smollar, 1985). However, results of the analysis found no significant differences. Hypothesis VIII considered these same factors, except that the observer's gender was female. Hypothesis VIII specified female observers would provide stronger working alliance ratings for female recipients of similar disclosures versus male recipients of similar disclosures. However, results from the analysis found no significant differences. Therefore, it can be assumed the gender of the observer and of the recipient of the disclosure did not significantly differentiate between male and female observers on their ratings of the working alliance.

As to why the observer's gender and of the recipient of the disclosure did not significantly differentiate between observers on their ratings of the working alliance, one can only speculate. One factor that may have had an impact was the strength of the observers' internalized gender role identity. As was mentioned before, the strength of one's internalized

gender identity may affect their utilization of self-disclosure (Derlega et al., 1993). In fact, observers considered to have strongly internalized gender role identity might allow gender to have a more intensified effect in how much they utilize self-disclosure in their close relationships (Derlega et al., 1993). Unfortunately, there is no way to determine whether this was a factor, as the current study did not assess the observers' in terms of the strength of their internalized gender role identity.

Additional Analyses

Although the primary analysis did not reveal significant findings on the overall measure of the working alliance, subsequent analysis did determine observer gender and disclosure type resulted in significant differences on observer ratings of the therapist/client bond and task agreement as measures of the working alliance. However, this occurred only for the female observers. The finding that only the female observers differentiated on their ratings of the working alliance might suggest they were the only ones who were comfortable with the emotional nature of the constructed therapy vignettes. This is not unlike prior research that found women place more emphasis on intimate communication in same-sex relationships compared to men (Caldwell & Peplau, 1982), while also holding to gender goals considered to be social-emotional and communal in nature (Derlega et al., 1993).

In terms of the significant findings, female observers rated male clients who received similar therapist disclosures stronger on therapist/client bond than male clients who received dissimilar therapist disclosures. However, when similar, dissimilar, and no therapist disclosures were observed in the context of the female client, there were no differences on female observer ratings of the therapist/client bond. Perhaps the disclosures with male clients appeared more unusual from the lens of the female observer. Based on this logic, perhaps the disclosures in the

female context failed to have an affect, because they were not perceived as unusual. As a matter of fact, prior research has found disclosure to be more commonplace in female-female relationships (Caldwell & Peplau, 1982) and for women to place more emphasis on intimate communication in same-sex relationships than men (Caldwell & Peplau, 1982; Youniss & Smollar, 1985). However, this study's utilization of therapist disclosures in the context of female participants was not unlike others who achieved significant effects from close to the same number of disclosures (Mann & Murphy, 1975). Consequently, one is left to wonder whether the number of disclosures in the context of the female client was enough. However, previous research indicated less of a positive effect for disclosures employed at both a greater and lesser rate than disclosures employed at a moderate rate (Cash & Salzbach, 1978; Giannandrea & Murphy, 1973; Mann & Murphy, 1975)

The question also is raised as to whether the disclosures in the context of the female client were viewed by the female observers as being too personal. Prior research found women have concerns about the impact of their own personal disclosures upon their female therapists (Dailey, 2004); whereas women in weak client/therapist working alliances have more negative evaluations of therapist self-disclosure than female recipients of self-disclosure in strong working alliances (Myers, 2004). However, there is no way to determine whether the female observers believed the disclosures were too personal and what their estimations were of the perceived strength of the working alliance between the client and therapist in the therapy vignettes. Female observers assigned stronger bond ratings as a measure of the working alliance for similar disclosure in the context of male versus female clients. Again, perhaps the female observers assigned higher bond ratings to the male client, because the disclosures were perceived as less commonplace in the male context. Moreover, perhaps the personal nature of the similar

disclosures in the context of the female clients was seen as too personal by the female observers. Lastly, this study found a significant interaction between the sex of the therapist, disclosure type, and collection group (e.g., engineering, social work, human ecology). However, this finding was called into question due to there being a sizable difference in the sample sizes for the different collection groups. Future studies are recommended to investigate this finding further.

Implications

The aims of this section are threefold. This section addresses the findings in terms of how they fit into the context of prevailing theoretical models, particularly their consistency and inconsistency with these models. Second, this section discusses the findings in terms of future research implications, particularly how they might pave the way for future studies concerning therapist disclosure, gender composition of the therapy dyad, gender of the observer and the working alliance. Lastly, this section discusses the findings in terms of their practical application, how they might serve the world of practice, and whether there could be any limitations in doing so.

Theoretical and Research Implications

In his balance theory, Heider (1958) suggested several years ago perceived similarity between two objects should induce a harmonious sentiment relationship; whereas Bandura (1971) suggested a reduction in anxiety would be found for those who witnessed others with similar behavior. Since that time, several studies have produced favorable findings for similar therapist and interviewer disclosure (Cash & Salzbach, 1978; Giannandrea & Murphy, 1973; Mann & Murphy, 1975; Nyman & Daugherty, 2001; Peca-Baker & Friedlander, 1989). Subsequently, it was expected manipulations in disclosure type would produce significant findings. However, the results of this study were not congruent with past research that found

type of therapist disclosures had a significant impact on recipient and observer perceptions (Cash & Salzbach, 1978; Giannandrea & Murphy, 1973; Mann & Murphy, 1975; Nyman & Daugherty, 2001; Peca-Baker & Friedlander, 1989). In fact, this study found disclosure type has no differential effect on observer ratings of the overall working alliance, a dependent variable that had not been studied previously in therapist disclosure type studies (Myers, 2004). This study, however, was similar to many of the disclosure studies that found context plays an important role in recipient and observer ratings of the sender's utilization of disclosure (Cash & Salzbach, 1978; Giannandrea & Murphy, 1973; Mann & Murphy, 1975). Context appeared to have an effect in the current study because disclosure type and sex of the client influenced female observer ratings of the bond as a measure of the working alliance. Perhaps female preferences for intimacy (Bernstein et al., 1987; Blier et al., 1987; Boulware & Holmes, 1970) had some influence. However, if this was the case, why then did the female observers' not assign stronger working alliances for both male and female clients in the similar disclosure scenarios? Perhaps, prior research that found female clients to avoid personal disclosures with their female therapists had some bearing (Dailey, 2004).

Context of disclosure has been explored from the viewpoint of one's theoretical perspective. As was noted earlier, feminists have advocated for therapist disclosure, whereas psychoanalysts have had reservations with the therapist's utilization of disclosure (Simi & Mahalik, 1997). Moreover, disclosure has been considered from the context of theoretical conceptualizations of interpersonal relationship development. Knapp and Vangelisti's (1991) proposal of a staircase model of relationship development postulated disclosure and interpersonal relationships would unfold through a process of mutual transformation. Moreover, they argued disclosure as a medium would likely only be relegated to the latter stages of one's relationship

development. However, should disclosure take place early in one's relationship development, it would most likely be impersonal and of a positive nature (Knapp & Vangelisti, 1991). Knapp and Vangelisti's (1991) conceptualization of intimacy suggested, just like stairs in a staircase, intimacy was often systematic and sequential, with the early stages laying the groundwork for later stages.

Perhaps the observers in this study found the disclosures too personal and negative, and perhaps they felt the disclosures were implemented too early in the therapist/client relationship. Myers (2004) found disclosures made early in the stages of the therapy relationship resulted in negative participant ratings of the working alliance. However, one might question whether the current study's observers considered the disclosures as being implemented too early in the therapist/client relationship, given the fact that the disclosures did not result in weaker observer working alliance ratings compared to the no disclosure condition.

Additionally, when one considers the implementation of therapist disclosure into the therapy relationship, what is considered too early? In terms of Myers' (2004) study, early was conceptualized in terms of the strength of the working alliance. However, regardless of the strength of the working alliance, research has found positive results for therapist disclosure when implemented into a ruptured therapeutic alliance between the client and the therapist (Safran & Muran, 1996) and into situations where therapy clients have been characterized as highly reactant, (Beitman & Yue, 1999). Therefore, it is difficult to know the exact relationship between disclosure and the working alliance, and whether this study's utilization of disclosure type interacted with the therapist/client's working alliance or stage of therapist/client relationship development. Subsequently, research should investigate this issue further, perhaps replicating

this study and examining disclosure type in the context of strength of the working alliance as well as the stage of the client/therapist relationship.

Another factor that may have been a limitation concerns the differences between the types of disclosure. In particular, how different were the dissimilar disclosures from the similar disclosures? In fact, both of the therapy scenarios were identical in the sense that the therapist voiced the loss of their parent to their client. However, they were different in the sense that the therapist's utilization of a similar disclosure involved the loss of their parent through death, whereas the dissimilar disclosure involved the loss of the therapist's parent through divorce. From an observer point of view, is the loss of a therapist's parent through divorce dissimilar, or to what degree dissimilar, to a client's loss of their parent through death?

Gender composition of the therapy dyad and gender of the observer were also factors considered in this study. It was proposed the exploration of these factors might help to answer the call prior researchers' had made to examine disclosure type in the context of gender, while also considering these effects in the context of the working alliance as a dependent variable (Myers, 2004; Watkins, 1989). However, this study failed to produce significant differences for these factors on observer ratings of the working alliance.

Although no significant differences were found for type of the disclosure, gender of the observer, and gender composition of the therapy dyad, perhaps the lack of findings can best be understood within the context of prior research. Specifically, there is an inconsistency of findings concerning male and female preferences for intimacy, disclosure, gender of the therapist, and preferences for disclosure in the context of the other person's gender (Bernstein et al., 1987; Blase, 1977, Blier et al., 1987; Boulware & Holmes, 1970; Dailey, 2004; David & Brannon, 1976; Dindia & Allen, 1992; Fisher & Good, 1997; Fowler et al., 1992; Fuller, 1963; Howard et

al., 1970; Johnson, 2005; Levant, 1992; Napier, 1991; Scher, 1979, 2005; Youniss & Smollar, 1985; Zones & Zoppel, 1982). Perhaps, this study further confirms that findings in this area of research are equivocal. Additionally, one might question other factors, such as the degree to which the observers adhered to their own gender-role identification. Prior research had revealed those constituted as androgynous with their gender-role identification are more disclosing than those not as androgynous (Myers, 2004). In fact, Derlega et al. (1993) postulated that for only those with strongly internalized gender-role identities, gender may have a strong influence on self-disclosure in close relationships versus those without strongly internalized gender-role identities. Consequently, the failure to find an effect for gender may have been attributed to the observer's strength of internalized gender-role identity, as well as to how androgynous the observers were with respect to gender. However, the present findings provide no certainty about this, and researchers should explore this relationship further.

Conversely, context did play a role with respect to therapist-client bond. Female observers perceived male clients who received similar disclosures as having a stronger bond than male clients who received dissimilar therapist disclosures. Moreover, female observers assigned stronger ratings to male versus female clients, but only in the similar disclosure condition. No prior studies could be found for the first finding that female observers have greater impressions of similar versus dissimilar disclosure in the context of the male client. Consequently, it is difficult to know how this finding fits into the context of prior research, except that it adds to the examination of therapist disclosure in a new context. However, one comparison might be the research of Cash and Salzbach (1978) who found female observers rate unattractive male therapists higher on facilitative conditions of empathy, regard, and genuineness as a result of their utilization of similar disclosures versus no therapist disclosures. Cash and Salzbach (1978)

reasoned that the similar disclosures most likely achieved a greater positive effect as they provided the clients with a successful coping model and an optimistic expectation as what to expect in therapy as an ultimate gain. However, an exact comparison with this study is not possible because they did not compare similar to dissimilar disclosures.

In terms of the second finding, that the female observers' perceived stronger bond ratings for similar disclosure for male versus female clients, there were no studies which examined this exact comparison. However, some research examined female impressions of both male and female disclosers separately (Cash & Salzbach, 1978; Mann & Murphy, 1975; Peca-Baker & Friedlander, 1989). For instance, female observers have favorable impressions of male disclosers of similar disclosure (Cash & Salzbach, 1978). However, it was difficult to determine whether the similar disclosures were the sole determinant of the favorable findings. In fact, equal findings were found for both the dissimilar and similar disclosures, administered at a moderate level (Mann & Murphy, 1975). Thus, one is forced to conclude similarity of disclosure was just one of the contributors to the favorable ratings. Moreover, Peca-Baker and Friedlander (1989) explored type of disclosure in the context of female therapists, but found no differential effects on female observer ratings of therapist attractiveness, trustworthiness, and empathy.

Subsequently, similar disclosures from the female's point of view may be more favorable in the context of the male individual. To some, this may be surprising, given past evidence intimacy and disclosure are more commonplace in the context of women (Caldwell & Peplau, 1992; Youniss & Smollar, 1985). However, the similarity of the disclosures may have been more favorable in the situation of the male individual, given the belief the disclosures may have been seen as more unusual. Also, perhaps the female observers found the similar disclosures in the context of the female clients less appealing, because Myers (2004) found female clients to be

fearful about the impact of their personal disclosures when it involved female therapists as their recipients.

Implications for Practice

One of the chief aims of this study was to determine how the expected findings might inform the world of practice. It was anticipated the hypothesized outcomes would help to generate greater clarity about when practitioners should utilize therapist disclosure in terms of its type and the gender composition of the therapy dyad. Moreover, there would be greater clarity about when to utilize similar, dissimilar, and no therapist disclosure in the context of varied therapy gender arrangements: male/therapist/male client; female therapist/female client; male therapist/female client; female therapist/male client. However, as was noted earlier, the results of this examination found no significant differences on observer ratings of the overall measure of the working alliance. Consequently, it is difficult to suggest to practitioners which situations they should use particular types of therapist disclosure. Perhaps, one of the shortcomings of this study was that it did not ask the right questions. In particular, although it appeared that the similarity or dissimilarity of the disclosures was not enough of a factor to significantly differentiate observers' on their ratings of the working alliance, perhaps there are other variables of influence? For instance, might similar and dissimilar disclosures be received differently by therapists who are assessed to be narcissistic and who do not promote client empowerment versus those who promote client empowerment and are not narcissistic?

However, results from the additional analyses did reveal an effect on observers' ratings of the bond as a measure of the working alliance. Consequently, there may be some practical implications to the findings. Female observers assigned stronger bond ratings to similar disclosure with male clients than similar disclosure with female clients. Consequently, one might

recommend future practitioners should utilize similar disclosure with male clients. However, one should also remember these findings were not found for the male observers, and should they choose to utilize similar disclosure with male clients, therapists should also be cognizant some men struggle with intimacy and vulnerability (Scher, 2005), fear one another (Scher, 1979), lack skill with emotions (Robertson, 2005), and struggle with competitiveness (Johnson, 2005; Scher, 2005). However, if one examines the research closely, men utilize female therapists more than male therapists (Johnson, 2005), due, in part, to male expectations women are more knowledgeable about relationship issues and provide a safer environment for therapy. Consequently, men might prefer women's utilization of similar disclosure in the context of the male client. However, therapists should heed the advice of Johnson (2005) who encouraged female therapists to move slowly in their implementation of disclosure with male clients.

Female observers also assigned stronger bond ratings to similar versus dissimilar disclosure in the context of the male client. Perhaps this indication of female preferences for similarity and is one of the reasons men seek out female therapists more than male therapists? Again, the practitioner should consider this finding in the context of other research on men's difficulty with intimacy and vulnerability (Scher, 2005), and their slowness toward disclosure (Johnson, 2005). Moreover, this effect was found only for the female observer. Female practitioners should consider there were no significant differences on male observer comparisons of similar versus dissimilar disclosure. However, past research should also be considered. Mann and Murphy (1973) found a greater return rate for male recipients of similar disclosure from a male interviewer, compared to few or many similar disclosures; whereas Nyman and Daugherty (2001) found male recipients of a single congruent disclosure resulted in positive findings.

Consequently, one is advised to consider past and present research concerning similar disclosure and the male client.

Lastly, the practitioner is cautioned there were no differences in female observers' ratings of similar, dissimilar, and no disclosure in the context of the female client. However, incongruent with this study's findings, Mann and Murphy (1975) did find similar and dissimilar disclosures at a moderate frequency equally increased the recipient's reciprocation of disclosure; whereas Nyman and Daugherty (2001) found female observers have a greater impression of a congruent versus incongruent disclosure. Consequently, one is advised to consider the ambiguous nature of the findings for this topic. Additionally, one is advised to consider the research of Dailey (2004) who investigated the topic of therapist disclosure and found female participants struggle with how their disclosures are received by their female therapists. Consequently, the body of literature is ambiguous, and female practitioners should consider all of these findings before utilizing disclosure with their female clients.

Limitations of the Study

There are a number of limitations with this study. First, it was anticipated there would be an adequate number of participants for each of the research conditions, so as to ensure an adequate effect and to avoid the issue of outliers or extreme scores inflating the results in one direction or another. According to Hair, Anderson, Tatham, and Black (1998), it is recommended that one utilize an adequate sample size for studies involving the ANOVA factorial design, and that this involve a sample size of ($n = 20$) for each of the research conditions. Although there were a large number of individuals who participated in this study ($N= 357$), many of the conditions did not meet the recommended sample size, which reduced statistical power.

Subsequently, should this study once again be conducted, consideration of sample size is strongly recommended.

A second limitation concerns the measure of the working alliance inventory (WAI-O). The goal, bond, and task subscales were highly correlated with one another. As such, this leads one to question whether the instrument's scales were truly separate scales and whether they actually measured what they were designed to measure. A third limitation, similar to many of the previously conducted disclosure studies, was this study's analogue design. Consequently, the participants' reaction to the therapy transcripts might not have adequately represented how actual clients would have perceived the factors of therapist gender and disclosure type. In fact, the participants' ratings might only have reflected how they perceived they might have felt in a therapy situation. This limitation is similar to all other disclosure studies that were reviewed and did not use actual therapy clients. However, many of those studies did utilize a live setting involving the participants' reactions to a live interviewer or therapist. Consequently, that may have created a more realistic therapy scenario in those studies, which consequently led to a greater effect for the research variables.

Another potential limitation might have been that the research participants only observed one of the therapy transcripts. Consequently, the participants may have lacked a frame of reference for comparison, which might have otherwise enabled them to determine their preferences for disclosure type and gender composition of the therapy dyad. Fifth, another possible limitation may have concerned the therapy transcripts, in and that they always illustrated the loss of the therapist's same-sexed parent. Perhaps, from an observer point of view, the loss of one's father is far different than the loss of one's mother. Consequently, the observers might not have equated a male therapist's loss of a father as similar to a female client's loss of a mother.

Sixth, the participants were of a very homogenous group in terms of their age, which limits the generalizability of the findings. Because most of the participants were young adults, this study really only addressed how participants in this age group might respond to disclosure type and gender composition of the therapy dyad. Participants in other age groups, with additional life experience, may have reacted differently to the therapy transcripts and thus generated different working alliance ratings.

Suggestions for Future Research

Future research should focus on addressing the limitations of the current study. An initial suggestion would be to increase the sample size for each of the research conditions to 20, because many of the conditions did not meet this recommended standard suggested for studies utilizing the ANOVA factorial design. Quite possibly, lack of statistical significance could have been due to less than desirable statistical power. A second suggestion for future research would be for future researchers to create a more realistic context for the research variables.

Replacement of this study's utilization of a script format with a video format might strengthen the realistic nature of the therapy scenarios as well as facilitate a greater saliency and realism for the research variables. Furthermore, consistent with the recommendation made by Watkins (1990), future researchers should attempt to move studies into the field. As such, this would require moving this study from the analogue format to a format utilizing actual therapists and clients. Consequently, this might also help to enhance the validity and generalizability of the findings.

Additionally, future researchers should investigate the interactive effects between gender traits, subject sex, and therapist disclosure, because prior studies have only examined one sex's disclosure upon another. This study did aim to respond to this recommendation. However, future

researchers should investigate strength of the participants' internalized gender-role identity as well as the participants' degree of androgyny, because past research has suggested physical gender is not a sole determinant of one's utilization of disclosure (Dailey, 2004). Consequently, such measures may help to ensure gender is a potent enough variable to have an experimental effect.

Future research should also consider the stage of the therapist/client relationship, and whether administration of the research factors at different stages of this relationship would translate into different findings. Essentially, would therapist disclosures be received differently when implemented later in the therapy relationship as opposed to earlier? Future research should also investigate the utilization of a within-subjects design, but at the same time acknowledge the limitations of a within-subjects design: differential carryover effects, practice effects, and fatigue. Perhaps to address these multiple concerns, participants could be exposed to all of the disclosure type conditions, however, they would only be asked to provide a single working alliance rating for one of the scenarios. Assignment of future participants in this case would require the scenarios to be counterbalanced, so as to have an equal representation of participants for each of the scenarios. Lastly, future research should investigate whether this study's research factors would be received differently in terms of the strength of the working alliance, because prior research has found therapist disclosure to be evaluated differently when it concerns strength of the alliance? In particular, how might post-observer working alliance ratings compare to pre-established observer ratings from the therapist implementation of similar, dissimilar, and no disclosure?

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Appendix A

Please imagine yourself as an objective observer of a therapy session between a therapist and a client. In the following scenario, a male therapist is working with a female client by the name of Bridgett. Bridgett has come to the University's Counseling Center to explore the concerns she has over the recent loss of her mother to cancer, and how this loss has been affecting her ability to attend to her classes, her grades, and her ability to cope.

(Male therapist/Female client - "Bridgett")

Therapist: Hello Bridgett, so what brings you in?

Client: I'm not sure?

Therapist: What's on your mind?

Client: Oh, lots of things.

Therapist: Such as?

Client: School and all, my grades I don't know, I'm just tired, been pretty consumed and kind of confused.

Therapist: Confused about what?

Client: Well, family stuff.

Therapist: Mm hmm, what's going on with your family?

Client: Oh I don't know, where do I begin, there is so much...

Therapist: How about the beginning?

Client: Well, it's like this, my mom died six months ago. It was pretty sudden, she was doing great, healthy and all, until they found it?

Therapist: What did they find?

Client: A tumor, then she was gone, it was too fast. I still just can't believe it. There was

no warning.

Therapist: It took you by surprise, didn't it?

Client: Yeah, I'm just really struggling with everything.

Therapist: Tell me about how you are dealing with things now.

Client: Just trying to cope day by day.

Therapist: It's hard isn't it?

Client: (client nods), I'm just wanting to work through it, it's interfering with everything,

but I'm just having a hard time with it. You know when I was home, I could journal, do things my mom and I use to do together, stay in bed if I wanted, talk to family and friends.

Therapist: You've had a hard time doing those things here huh?

Client: Well it is hard to do these things with a roommate. You know

the other day, I had one of those really tough days. I had a really big exam and couldn't stop thinking of my mom. I probably flunked it! Not that it matters, I'll probably flunk out of the class anyway. Well anyway, I just got back to my room after the exam and I just wanted to be alone with my thoughts, but there she was, my roommate, had all of her friends over, watching some dumb movie. I couldn't exactly express myself there?

Therapist: That tough huh?

Client: Definitely. She doesn't even have a clue. I said something to her once about it,

when I first got to campus and she just changed the subject on me, talking about something insignificant. She has no clue, she comes from a picture perfect family.

Therapist: What do you wish you could have done?

Client: I just wish I could have had some time to myself. It's just been so hard, I'm going

through all of these changes and she is not here for me. She wasn't here to help me move into my dorm room like all of the other kids. It's not just the same with my dad.

Therapist: Sounds like coming to college has been a big transition for you that has been compounded by the recent loss of your mother. This must be an extremely difficult time for you?

Client: Yeah.

Therapist: You know Bridgett, I think that I can kind of relate to you, having had a similar experience myself. I can remember losing my own dad, I was 16 and I just didn't know how to get through it. I still often think of his missing out on all of the changes that have occurred in my own life.

Client: I just wish she was here.

Therapist: What would you tell her?

Client: That I'm really angry, that I didn't want her to leave me and that I need her, especially with all of the changes occurring in my life.

Therapist: Mmm hmm.

Client: What am I supposed to do?

Therapist: What would your mother tell you to do?

Client: Oh that's easy, she would know exactly what to do, she was a really strong person. She would tell me to not give up, to be strong.

Therapist: Does it help to think of how she would be encouraging to you now?

Client: Yeah, but it's not enough.

Therapist: But it helps some?

Client: Yes.

Therapist: Well then this could be one of the many tools you use to cope with this loss. Bridgett, I could tell you from experience that losing a parent is extremely difficult and probably one of the hardest things that you will experience. But there are ways to make it easier such as you just mentioned. After my dad died, I wrote down many of the little sayings that he used to use. My dad, kind of like your mom would tell me not to give up and to be strong. It helps to reflect back on those from time to time, just as it helps you to think of the advice that your mother would give you now.

Client: But how do I cope when I am sharing a very small living space with a roommate who might as well come from the perfect family?

Therapist: That's a great question. Since this loss is so recent you will have some difficult times ahead of you. One thing that I think would help would be for us to continue our work together, but you still have to process on your own. Do you have any ideas as to get around the roommate issue?

Client: Not really, I was hoping you could help with that.

Therapist: Well here is an idea that worked for me, after my dad died I felt miserable.

Client: Tell me about it.

Therapist: I came to a point that I decided I didn't want to live in misery anymore. I was tired of everyone feeling sorry for me.

Client: But it's not like you can just forget that it happened.

Therapist: Exactly. So here is what I did. I would allow myself 30 minutes a day to be sad and grieve. I would do whatever it was that I felt I needed for those 30 minutes,

then I would visualize myself putting away my pain on a shelf in my mind until the next day when I would pull it out again.

Client: And this really worked?

Therapist: Well to be honest, not every time but usually.

Client: Well I am willing to give anything a shot.

Therapist: Good, I'm glad that you're here working on things. Like you, I also saw a therapist when I was working through things and I learned that it took that kind of an attitude.

Therapist: Do you have 30 minutes a day when your roommate will be out?

Client: Yeah, our class schedules are a little different.

Therapist: Well then make it a part of your daily schedule and come back in a week. I would really like to continue our work, like I said I know that this can be extremely difficult.

Client: Thanks for the help!

In the previous scenario:

The gender of the therapist was: Male _____ Female _____

The gender of the client was: Male _____ Female _____

Appendix B

Please imagine yourself as an objective observer of a therapy session between a therapist and a client. In the following scenario, a female therapist is working with a male client by the name of David. David has come to the University's Counseling Center to explore the concerns he has over the recent loss of his father to cancer, and how this loss has been affecting his ability to attend to his classes, his grades, and his ability to cope.

(Female therapist/Male client – “David”)

Therapist: Hello David, so what brings you in?

Client: I'm not sure?

Therapist: What's on your mind?

Client: Oh, lots of things.

Therapist: Such as?

Client: School and all, my grades I don't know, I'm just tired, been pretty consumed and kind of confused.

Therapist: Confused about what?

Client: Well, family stuff.

Therapist: Mm hmm, what's going on with your family?

Client: Oh I don't know, where do I begin, there is so much...

Therapist: How about the beginning?

Client: Well, it's like this, my dad died six months ago. It was pretty sudden, he was doing great, healthy and all, until they found it?

Therapist: What did they find?

Client: A tumor, then he was gone, it was too fast. I still just can't believe it. There was

no warning.

Therapist: It took you by surprise, didn't it?

Client: yeah, I'm just really struggling with everything.

Therapist: Tell me about how you are dealing with things now.

Client: Just trying to cope day by day.

Therapist: It's hard isn't it?

Client: (client nods), I'm just wanting to work through it, it's interfering with everything,

but I'm just having a hard time with it. You know when I was home, I could journal, do things my dad and I use to do together, stay in bed if I wanted, talk to family and friends.

Therapist: You've had a hard time doing those things here huh?

Client: Well it is hard to do these things with a roommate. You know

the other day, I had one of those really tough days. I had a really big exam and couldn't stop thinking of my dad. I probably flunked it! Not that it matters, I'll probably flunk out of the class anyway. Well anyway, I just got back to my room after the exam and I just wanted to be alone with my thoughts, but there he was, my roommate, had all of his friends over, watching some dumb movie. I couldn't exactly express myself there?

Therapist: That tough huh?

Client: Definitely. He doesn't even have a clue. I said something to him once about it,

when I first got to campus and he just changed the subject on me, talking about something insignificant. He has no clue, he comes from a picture perfect family.

Therapist: What do you wish you could have done?

Client: I just wish I could have had some time to myself. It's just been so hard, I'm going

through all of these changes and he is not here for me. He wasn't here to help me move into my dorm room like all of the other kids. It's not just the same with my mom.

Therapist: Sounds like coming to college has been a big transition for you that has been compounded by the recent loss of your dad. This must be an extremely difficult time for you?

Client: Yeah.

Therapist: You know David, I think that I can kind of relate to you, having had a similar experience myself. I can remember losing my own mom, I was 16 and I just didn't know how to get through it. I still often think of her missing out on all of the changes that have occurred in my own life.

Client: I just wish he was here

Therapist: What would you tell him?

Client: That I'm really angry, that I didn't want him to leave me and that I need him, especially with all of the changes occurring in my life.

Therapist: Mmm hmm.

Client: What am I supposed to do?

Therapist: What would your dad tell you to do?

Client: Oh that's easy, he would know exactly what to do, he was a really strong person. He would tell me to not give up, to be strong.

Therapist: Does it help to think of how he would be encouraging to you now?

Client: Yeah, but it's not enough.

Therapist: But it helps some?

Client: Yes.

Therapist: Well then this could be one of the many tools you use to cope with this loss. David, I could tell you from experience that losing a parent is extremely difficult and probably one of the hardest things that you will experience. But there are ways to make it easier such as you just mentioned. After my mom died, I wrote down many of the little sayings that she used to use. My mom, kind of like your dad would tell me not to give up and to be strong. It helps to reflect back on those from time to time, just as it helps you to think of the advice that your dad would give you now.

Client: But how do I cope when I am sharing a very small living space with a roommate who might as well come from the perfect family?

Therapist: That's a great question. Since this loss is so recent you will have some difficult times ahead of you. One thing that I think would help would be for us to continue our work together, but you still have to process on your own. Do you have any ideas as to get around the roommate issue?

Client: Not really, I was hoping you could help with that.

Therapist: Well here is an idea that worked for me, after my mom died I felt miserable.

Client: Tell me about it.

Therapist: I came to a point that I decided I didn't want to live in misery anymore. I was tired of everyone feeling sorry for me.

Client: But it's not like you can just forget that it happened.

Therapist: Exactly. So here is what I did. I would allow myself 30 minutes a day to be sad and grieve. I would do whatever it was that I felt I needed for those 30 minutes,

then I would visualize myself putting away my pain on a shelf in my mind until the next day when I would pull it out again.

Client: And this really worked?

Therapist: Well to be honest, not every time but usually.

Client: Well I am willing to give anything a shot.

Therapist: Good, I'm glad that you're here working on things. Like you, I also saw a therapist when I was working through things and I learned that it took that kind of an attitude.

Therapist: Do you have 30 minutes a day when your roommate will be out?

Client: Yeah, our class schedules are a little different.

Therapist: Well then make it a part of your daily schedule and come back in a week. I would really like to continue our work, like I said I know that this can be extremely difficult.

Client: Thanks for the help!

In the previous scenario:

The gender of the therapist was: Male _____ Female _____

The gender of the client was: Male _____ Female _____

Appendix C

Please imagine yourself as an objective observer of a therapy session between a therapist and a client. In the following scenario, a male therapist is working with a male client by the name of David. David has come to the University's Counseling Center to explore the concerns he has over the recent loss of his father to cancer, and how this loss has been affecting his ability to attend to his classes, his grades, and his ability to cope.

(Male therapist/Male client – “David”)

Therapist: Hello David, so what brings you in?

Client: I'm not sure?

Therapist: What's on your mind?

Client: Oh, lots of things.

Therapist: Such as?

Client: School and all, my grades I don't know, I'm just tired, been pretty consumed and kind of confused.

Therapist: Confused about what?

Client: Well, family stuff.

Therapist: Mm hmm, what's going on with your family?

Client: Oh I don't know, where do I begin, there is so much...

Therapist: How about the beginning?

Client: Well, it's like this, my dad died six months ago. It was pretty sudden, he was doing great, healthy and all, until they found it?

Therapist: What did they find?

Client: A tumor, then he was gone, it was too fast. I still just can't believe it. There was

no warning.

Therapist: It took you by surprise, didn't it?

Client: Yeah, I'm just really struggling with everything.

Therapist: Tell me about how you are dealing with things now.

Client: Just trying to cope day by day.

Therapist: It's hard isn't it?

Client: (client nods), I'm just wanting to work through it, it's interfering with everything,

but I'm just having a hard time with it. You know when I was home, I could journal, do things my dad and I use to do together, stay in bed if I wanted, talk to family and friends.

Therapist: You've had a hard time doing those things here huh?

Client: Well it is hard to do these things with a roommate. You know

the other day, I had one of those really tough days. I had a really big exam and couldn't stop thinking of my dad. I probably flunked it! Not that it matters, I'll probably flunk out of the class anyway. Well anyway, I just got back to my room after the exam and I just wanted to be alone with my thoughts, but there he was, my roommate, had all of his friends over, watching some dumb movie. I couldn't exactly express myself there?

Therapist: That tough huh?

Client: Definitely. He doesn't even have a clue. I said something to him once about it,

when I first got to campus and he just changed the subject on me, talking about something insignificant. He has no clue, he comes from a picture perfect family.

Therapist: What do you wish you could have done?

Client: I just wish I could have had some time to myself. It's just been so hard, I'm going

through all of these changes and he is not here for me. He wasn't here to help me move into my dorm room like all of the other kids. It's not just the same with my dad.

Therapist: Sounds like coming to college has been a big transition for you that has been compounded by the recent loss of your dad. This must be an extremely difficult time for you?

Client: Yeah.

Therapist: You know David, I think that I can kind of relate to you, having had a similar experience myself. I can remember losing my own dad, I was 16 and I just didn't know how to get through it. I still often think of his missing out on all of the changes that have occurred in my own life.

Client: I just wish he was here.

Therapist: What would you tell him?

Client: That I'm really angry, that I didn't want him to leave me and that I need him, especially with all of the changes occurring in my life.

Therapist: Mmm hmm.

Client: What am I supposed to do?

Therapist: What would your dad tell you to do?

Client: Oh that's easy, he would know exactly what to do, he was a really strong person. He would tell me to not give up, to be strong.

Therapist: Does it help to think of how he would be encouraging to you now?

Client: Yeah, but it's not enough.

Therapist: But it helps some?

Client: Yes.

Therapist: Well then this could be one of the many tools you use to cope with this loss. David, I could tell you from experience that losing a parent is extremely difficult and probably one of the hardest things that you will experience. But there are ways to make it easier such as you just mentioned. After my dad died, I wrote down many of the little sayings that he used to use. My dad, kind of like your dad would tell me not to give up and to be strong. It helps to reflect back on those from time to time, just as it helps you to think of the advice that your dad would give you now.

Client: But how do I cope when I am sharing a very small living space with a roommate who might as well come from the perfect family?

Therapist: That's a great question. Since this loss is so recent you will have some difficult times ahead of you. One thing that I think would help would be for us to continue our work together, but you still have to process on your own. Do you have any ideas as to get around the roommate issue?

Client: Not really, I was hoping you could help with that.

Therapist: Well here is an idea that worked for me, after my dad died I felt miserable.

Client: Tell me about it.

Therapist: I came to a point that I decided I didn't want to live in misery anymore. I was tired of everyone feeling sorry for me.

Client: But it's not like you can just forget that it happened.

Therapist: Exactly. So here is what I did. I would allow myself 30 minutes a day to be sad and grieve. I would do whatever it was that I felt I needed for those 30 minutes,

then I would visualize myself putting away my pain on a shelf in my mind until the next day when I would pull it out again.

Client: And this really worked?

Therapist: Well to be honest, not every time but usually.

Client: Well I am willing to give anything a shot.

Therapist: Good, I'm glad that you're here working on things. Like you, I also saw a therapist when I was working through things and I learned that it took that kind of an attitude.

Therapist: Do you have 30 minutes a day when your roommate will be out?

Client: Yeah, our class schedules are a little different.

Therapist: Well then make it a part of your daily schedule and come back in a week. I would really like to continue our work, like I said I know that this can be extremely difficult.

Client: Thanks for the help!

In the previous scenario:

The gender of the therapist was: Male _____ Female _____

The gender of the client was: Male _____ Female _____

Appendix D

Please imagine yourself as an objective observer of a therapy session between a therapist and a client. In the following scenario, a female therapist is working with a female client by the name of Bridgett. Bridgett has come to the University's Counseling Center to explore the concerns she has over the recent loss of her mother to cancer, and how this loss has been affecting her ability to attend to her classes, her grades, and her ability to cope.

(Female therapist/Female client – “Bridgett”)

Therapist: Hello Bridgett, so what brings you in?

Client: I'm not sure?

Therapist: What's on your mind?

Client: Oh, lots of things.

Therapist: Such as?

Client: School and all, my grades I don't know, I'm just tired, been pretty consumed and kind of confused.

Therapist: Confused about what?

Client: Well, family stuff.

Therapist: Mm hmm, what's going on with your family?

Client: Oh I don't know, where do I begin, there is so much...

Therapist: How about the beginning?

Client: Well, it's like this, my mom died six months ago. It was pretty sudden, she was doing great, healthy and all, until they found it?

Therapist: What did they find?

Client: A tumor, then she was gone, it was too fast. I still just can't believe it. There was

no warning.

Therapist: It took you by surprise, didn't it?

Client: Yeah, I'm just really struggling with everything.

Therapist: Tell me about how you are dealing with things now.

Client: Just trying to cope day by day.

Therapist: It's hard isn't it?

Client: (client nods), I'm just wanting to work through it, it's interfering with everything,

but I'm just having a hard time with it. You know when I was home, I could journal, do things my mom and I use to do together, stay in bed if I wanted, talk to family and friends.

Therapist: You've had a hard time doing those things here huh?

Client: Well it is hard to do these things with a roommate. You know

the other day, I had one of those really tough days. I had a really big exam and couldn't stop thinking of my mom. I probably flunked it! Not that it matters, I'll probably flunk out of the class anyway. Well anyway, I just got back to my room after the exam and I just wanted to be alone with my thoughts, but there she was, my roommate, had all of her friends over, watching some dumb movie. I couldn't exactly express myself there?

Therapist: That tough huh?

Client: Definitely. She doesn't even have a clue. I said something to her once about it,

when I first got to campus and she just changed the subject on me, talking about something insignificant. She has no clue, she comes from a picture perfect family.

Therapist: What do you wish you could have done?

Client: I just wish I could have had some time to myself. It's just been so hard, I'm going

through all of these changes and she is not here for me. She wasn't here to help me move into my dorm room like all of the other kids. It's not just the same with my dad.

Therapist: Sounds like coming to college has been a big transition for you that has been compounded by the recent loss of your mother. This must be an extremely difficult time for you?

Client: Yeah.

Therapist: You know Bridgett, I think that I can kind of relate to you, having had a similar experience myself. I can remember losing my own mom, I was 16 and I just didn't know how to get through it. I still often think of his missing out on all of the changes that have occurred in my own life.

Client: I just wish she was here.

Therapist: What would you tell her?

Client: That I'm really angry, that I didn't want her to leave me and that I need her, especially with all of the changes occurring in my life.

Therapist: Mmm hmm.

Client: What am I supposed to do?

Therapist: What would your mother tell you to do?

Client: Oh that's easy, she would know exactly what to do, she was a really strong person. She would tell me to not give up, to be strong.

Therapist: Does it help to think of how she would be encouraging to you now?

Client: Yeah, but it's not enough.

Therapist: But it helps some?

Client: Yes.

Therapist: Well then this could be one of the many tools you use to cope with this loss. Bridgett, I could tell you from experience that losing a parent is extremely difficult and probably one of the hardest things that you will experience. But there are ways to make it easier such as you just mentioned. After my mom died, I wrote down many of the little sayings that she used to use. My mom, kind of like your mom would tell me not to give up and to be strong. It helps to reflect back on those from time to time, just as it helps you to think of the advice that your mother would give you now.

Client: But how do I cope when I am sharing a very small living space with a roommate who might as well come from the perfect family?

Therapist: That's a great question. Since this loss is so recent you will have some difficult times ahead of you. One thing that I think would help would be for us to continue our work together, but you still have to process on your own. Do you have any ideas as to get around the roommate issue?

Client: Not really, I was hoping you could help with that.

Therapist: Well here is an idea that worked for me, after my mom died I felt miserable.

Client: Tell me about it.

Therapist: I came to a point that I decided I didn't want to live in misery anymore. I was tired of everyone feeling sorry for me.

Client: But it's not like you can just forget that it happened.

Therapist: Exactly. So here is what I did. I would allow myself 30 minutes a day to be sad and grieve. I would do whatever it was that I felt I needed for those 30 minutes,

then I would visualize myself putting away my pain on a shelf in my mind until the next day when I would pull it out again.

Client: And this really worked?

Therapist: Well to be honest, not every time but usually.

Client: Well I am willing to give anything a shot.

Therapist: Good, I'm glad that you're here working on things. Like you, I also saw a therapist when I was working through things and I learned that it took that kind of an attitude.

Therapist: Do you have 30 minutes a day when your roommate will be out?

Client: Yeah, our class schedules are a little different.

Therapist: Well then make it a part of your daily schedule and come back in a week. I would really like to continue our work, like I said I know that this can be extremely difficult.

Client: Thanks for the help!

In the previous scenario:

The gender of the therapist was: Male _____ Female _____

The gender of the client was: Male _____ Female _____

Appendix E

Please imagine yourself as an objective observer of a therapy session between a therapist and a client. In the following scenario, a male therapist is working with a female client by the name of Bridgett. Bridgett has come to the University's Counseling Center to explore the concerns she has over the recent loss of her mother to cancer, and how this loss has been affecting her ability to attend to her classes, her grades, and her ability to cope.

(Male therapist/Female client – “Bridgett”)

Therapist: Hello Bridgett, so what brings you in?

Client: I'm not sure?

Therapist: What's on your mind?

Client: Oh, lots of things.

Therapist: Such as?

Client: School and all, my grades I don't know, I'm just tired, been pretty consumed and kind of confused.

Therapist: Confused about what?

Client: Well, family stuff.

Therapist: Mm hmm, what's going on with your family?

Client: Oh I don't know, where do I begin, there is so much...

Therapist: How about the beginning?

Client: Well, it's like this, my mom died six months ago. It was pretty sudden, she was doing great, healthy and all, until they found it?

Therapist: What did they find?

Client: A tumor, then she was gone, it was too fast. I still just can't believe it. There was

no warning.

Therapist: It took you by surprise, didn't it?

Client: Yeah, I'm just really struggling with everything.

Therapist: Tell me about how you are dealing with things now.

Client: Just trying to cope day by day.

Therapist: It's hard isn't it?

Client: (client nods), I'm just wanting to work through it, it's interfering with everything,

but I'm just having a hard time with it. You know when I was home, I could journal, do things my mom and I use to do together, stay in bed if I wanted, talk to family and friends.

Therapist: You've had a hard time doing those things here huh?

Client: Well it is hard to do these things with a roommate. You know

the other day, I had one of those really tough days. I had a really big exam and couldn't stop thinking of my mom. I probably flunked it! Not that it matters, I'll probably flunk out of the class anyway. Well anyway, I just got back to my room after the exam and I just wanted to be alone with my thoughts, but there she was, my roommate, had all of her friends over, watching some dumb movie. I couldn't exactly express myself there?

Therapist: That tough huh?

Client: Definitely. She doesn't even have a clue. I said something to her once about it,

when I first got to campus and she just changed the subject on me, talking about something insignificant. She has no clue, she comes from a picture perfect family.

Therapist: What do you wish you could have done?

Client: I just wish I could have had some time to myself. It's just been so hard, I'm going

through all of these changes and she is not here for me. She wasn't here to help me move into my dorm room like all of the other kids. It's not just the same with my dad.

Therapist: Sounds like coming to college has been a big transition for you that has been compounded by the recent loss of your mother. This must be an extremely difficult time for you?

Client: Yeah.

Therapist: You know Bridgett I had a really tough loss when I was fifteen years old, my dad left when my parents were going through a divorce. It was a really tough time for me. My parents weren't getting along and they were always fighting. I remember my dad yelling a lot and saying a lot of bad things. I'm just glad that it doesn't hurt anymore.

Client: I just wish she was here.

Therapist: What would you tell her?

Client: That I'm really angry, that I didn't want her to leave me and that I need her, especially with all of the changes occurring in my life.

Therapist: Mmm hmm.

Client: What am I supposed to do?

Therapist: What would your mom tell you to do?

Client: Oh that's easy, she would know exactly what to do, she was a really strong person. She would tell me to not give up, to be strong.

Therapist: Does it help to think of how she would be encouraging to you now?

Client: Yeah, but it's not enough.

Therapist: But it helps some?

Client: Yes.

Therapist: Bridgett, I could tell you from my dad walking out on us that losing a parent through a divorce is extremely difficult and probably one of the hardest things that you could ever experience. But there are ways to make it easier such as what you just mentioned. After my dad left us I used to write him letters about the way that I was feeling, but I never had the courage to send them to him. Sometimes I wonder how he would have responded.

Client: But how do I cope when I am sharing a very small living space with a roommate who might as well come from the perfect family?

Therapist: That's a great question. Since this loss is so recent you will have some difficult times ahead of you. One thing that I think would help would be for us to continue our work together, but you still have to process on your own. Do you have any ideas as to get around the roommate issue?

Client: Not really, I was hoping you could help with that.

Therapist: Well here is an idea that worked for me, after my dad left I felt miserable.

Client: Tell me about it.

Therapist: I came to a point that I decided I didn't want to live in misery anymore. I was tired of everyone feeling sorry for me.

Client: But it's not like you can just forget that it happened.

Therapist: Exactly. So here is what I did. I would allow myself 30 minutes a day to be sad and grieve. I would do whatever it was that I felt I needed for those 30 minutes, then I would visualize myself putting away my pain on a shelf in my mind until the next day when I would pull it out again.

Client: And this really worked?

Therapist: Well to be honest, not every time but usually.

Client: Well I am willing to give anything a shot.

Therapist: Good, because that's essential, something that I wished I would have done right away. As a matter of fact, I wish that I would have taken the courage to seek a counselor's help, but I was young at the time and didn't understand things.

Therapist: Do you have 30 minutes a day when your roommate will be out?

Client: Yeah, our class schedules are a little different.

Therapist: Well then make it a part of your daily schedule and come back in a week. I would really like to continue our work, like I said I know that this can be extremely difficult.

Client: Thanks for the help!

In the previous scenario:

The gender of the therapist was: Male _____ Female _____

The gender of the client was: Male _____ Female _____

Appendix F

Please imagine yourself as an objective observer of a therapy session between a therapist and a client. In the following scenario, a female therapist is working with a male client by the name of David. David has come to the University's Counseling Center to explore the concerns he has over the recent loss of his father to cancer, and how this loss has been affecting his ability to attend to his classes, his grades, and his ability to cope.

(Female therapist/Male client – “David”)

Therapist: Hello David, so what brings you in?

Client: I'm not sure?

Therapist: What's on your mind?

Client: Oh, lots of things.

Therapist: Such as?

Client: School and all, my grades I don't know, I'm just tired, been pretty consumed and kind of confused.

Therapist: Confused about what?

Client: Well, family stuff.

Therapist: Mm hmm, what's going on with your family?

Client: Oh I don't know, where do I begin, there is so much...

Therapist: How about the beginning?

Client: Well, it's like this, my dad died six months ago. It was pretty sudden, he was doing great, healthy and all, until they found it?

Therapist: What did they find?

Client: A tumor, then he was gone, it was too fast. I still just can't believe it. There was

no warning.

Therapist: It took you by surprise, didn't it?

Client: Yeah, I'm just really struggling with everything.

Therapist: Tell me about how you are dealing with things now.

Client: Just trying to cope day by day.

Therapist: It's hard isn't it?

Client: (client nods), I'm just wanting to work through it, it's interfering with everything,

but I'm just having a hard time with it. You know when I was home, I could journal, do things my dad and I use to do together, stay in bed if I wanted, talk to family and friends.

Therapist: You've had a hard time doing those things here huh?

Client: Well it is hard to do these things with a roommate. You know

the other day, I had one of those really tough days. I had a really big exam and couldn't stop thinking of my dad. I probably flunked it! Not that it matters, I'll probably flunk out of the class anyway. Well anyway, I just got back to my room after the exam and I just wanted to be alone with my thoughts, but there he was, my roommate, had all of his friends over, watching some dumb movie. I couldn't exactly express myself there?

Therapist: That tough huh?

Client: Definitely. He doesn't even have a clue. I said something to him once about it,

when I first got to campus and he just changed the subject on me, talking about something insignificant. He has no clue, he comes from a picture perfect family.

Therapist: What do you wish you could have done?

Client: I just wish I could have had some time to myself. It's just been so hard, I'm going

through all of these changes and he is not here for me. He wasn't here to help me move into my dorm room like all of the other kids. It's just not the same with my mom.

Therapist: Sounds like coming to college has been a big transition for you that has been compounded by the recent loss of your dad. This must be an extremely difficult time for you?

Client: Yeah.

Therapist: You know David I had a really tough loss when I was fifteen years old, my mom left when my parents were going through a divorce. It was a really tough time for me. My parents weren't getting along and they were always fighting. I remember my mom yelling a lot and saying a lot of bad things. I'm just glad that it doesn't hurt anymore.

Client: I just wish he was here.

Therapist: What would you tell him?

Client: That I'm really angry, that I didn't want him to leave me and that I need him, especially with all of the changes occurring in my life.

Therapist: Mmm hmm.

Client: What am I supposed to do?

Therapist: What would your dad tell you to do?

Client: Oh that's easy, he would know exactly what to do, he was a really strong person. He would tell me to not give up, to be strong.

Therapist: Does it help to think of how he would be encouraging to you now?

Client: Yeah, but it's not enough.

Therapist: But it helps some?

Client: Yes.

Therapist: David, I could tell you from my mom walking out on us that losing a parent through a divorce is extremely difficult and probably one of the hardest things that you could ever experience. But there are ways to make it easier such as what you just mentioned. After my mom left us I used to write her letters about the way that I was feeling, but I never had the courage to send them to her. Sometimes I wonder how she would have responded.

Client: But how do I cope when I am sharing a very small living space with a roommate who might as well come from the perfect family?

Therapist: That's a great question. Since this loss is so recent you will have some difficult times ahead of you. One thing that I think would help would be for us to continue our work together, but you still have to process on your own. Do you have any ideas as to get around the roommate issue?

Client: Not really, I was hoping you could help with that.

Therapist: Well here is an idea that worked for me, after my dad left I felt miserable.

Client: Tell me about it.

Therapist: I came to a point that I decided I didn't want to live in misery anymore. I was tired of everyone feeling sorry for me.

Client: But it's not like you can just forget that it happened.

Therapist: Exactly. So here is what I did. I would allow myself 30 minutes a day to be sad and grieve. I would do whatever it was that I felt I needed for those 30 minutes, then I would visualize myself putting away my pain on a shelf in my mind until the next day when I would pull it out again.

Client: And this really worked?

Therapist: Well to be honest, not every time but usually.

Client: Well I am willing to give anything a shot.

Therapist: Good, because that's essential, something that I wished I would have done right away. As a matter of fact, I wish that I would have taken the courage to seek a counselor's help, but I was young at the time and didn't understand things.

Therapist: Do you have 30 minutes a day when your roommate will be out?

Client: Yeah, our class schedules are a little different.

Therapist: Well then make it a part of your daily schedule and come back in a week. I

would really like to continue our work, like I said I know that this can be extremely difficult.

Client: Thanks for the help!

In the previous scenario:

The gender of the therapist was: Male _____ Female _____

The gender of the client was: Male _____ Female _____

Appendix G

Please imagine yourself as an objective observer of a therapy session between a therapist and a client. In the following scenario, a male therapist is working with a male client by the name of David. David has come to the University's Counseling Center to explore the concerns he has over the recent loss of his father to cancer, and how this loss has been affecting his ability to attend to his classes, his grades, and his ability to cope.

(Male therapist/Male client – “David”)

Therapist: Hello David, so what brings you in?

Client: I'm not sure?

Therapist: What's on your mind?

Client: Oh, lots of things.

Therapist: Such as?

Client: School and all, my grades I don't know, I'm just tired, been pretty consumed and kind of confused.

Therapist: Confused about what?

Client: Well, family stuff.

Therapist: Mm hmm, what's going on with your family?

Client: Oh I don't know, where do I begin, there is so much...

Therapist: How about the beginning?

Client: Well, it's like this, my dad died six months ago. It was pretty sudden, he was doing great, healthy and all, until they found it?

Therapist: What did they find?

Client: A tumor, then he was gone, it was too fast. I still just can't believe it. There was

no warning.

Therapist: It took you by surprise, didn't it?

Client: yeah, I'm just really struggling with everything.

Therapist: Tell me about how you are dealing with things now.

Client: Just trying to cope day by day.

Therapist: It's hard isn't it?

Client: (client nods), I'm just wanting to work through it, it's interfering with everything,

but I'm just having a hard time with it. You know when I was home, I could journal, do things my dad and I use to do together, stay in bed if I wanted, talk to family and friends.

Therapist: You've had a hard time doing those things here huh?

Client: Well it is hard to do these things with a roommate. You know

the other day, I had one of those really tough days. I had a really big exam and couldn't stop thinking of my dad. I probably flunked it! Not that it matters, I'll probably flunk out of the class anyway. Well anyway, I just got back to my room after the exam and I just wanted to be alone with my thoughts, but there he was, my roommate, had all of his friends over, watching some dumb movie. I couldn't exactly express myself there?

Therapist: That tough huh?

Client: Definitely. He doesn't even have a clue. I said something to him once about it,

when I first got to campus and he just changed the subject on me, talking about something insignificant. He has no clue, he comes from a picture perfect family.

Therapist: What do you wish you could have done?

Client: I just wish I could have had some time to myself. It's just been so hard, I'm going

through all of these changes and he is not here for me. He wasn't here to help me move into my dorm room like all of the other kids. It's not just the same with my mom.

Therapist: Sounds like coming to college has been a big transition for you that has been compounded by the recent loss of your dad. This must be an extremely difficult time for you?

Client: Yeah.

Therapist: You know David I had a really tough loss when I was fifteen years old, my dad left when my parents were going through a divorce. It was a really tough time for me. My parents weren't getting along and they were always fighting. I remember my dad yelling a lot and saying a lot of bad things. I'm just glad that it doesn't hurt anymore.

Client: I just wish he was here.

Therapist: What would you tell him?

Client: That I'm really angry, that I didn't want him to leave me and that I need him, especially with all of the changes occurring in my life.

Therapist: Mmm hmm.

Client: What am I supposed to do?

Therapist: What would your dad tell you to do?

Client: Oh that's easy, he would know exactly what to do, he was a really strong person. He would tell me to not give up, to be strong.

Therapist: Does it help to think of how he would be encouraging to you now?

Client: Yeah, but it's not enough.

Therapist: But it helps some?

Client: Yes.

Therapist: David, I could tell you from my dad walking out on us that losing a parent through a divorce is extremely difficult and probably one of the hardest things that you could ever experience. But there are ways to make it easier such as what you just mentioned. After my dad left us I used to write him letters about the way that I was feeling, but I never had the courage to send them to him. Sometimes I wonder how he would have responded.

Client: But how do I cope when I am sharing a very small living space with a roommate who might as well come from the perfect family?

Therapist: That's a great question. Since this loss is so recent you will have some difficult times ahead of you. One thing that I think would help would be for us to continue our work together, but you still have to process on your own. Do you have any ideas as to get around the roommate issue?

Client: Not really, I was hoping you could help with that.

Therapist: Well here is an idea that worked for me, after my dad left I felt miserable.

Client: Tell me about it.

Therapist: I came to a point that I decided I didn't want to live in misery anymore. I was tired of everyone feeling sorry for me.

Client: But it's not like you can just forget that it happened.

Therapist: Exactly. So here is what I did. I would allow myself 30 minutes a day to be sad and grieve. I would do whatever it was that I felt I needed for those 30 minutes, then I would visualize myself putting away my pain on a shelf in my mind until the next day when I would pull it out again.

Client: And this really worked?

Therapist: Well to be honest, not every time but usually.

Client: Well I am willing to give anything a shot.

Therapist: Good, because that's essential, something that I wished I would have done right away. As a matter of fact, I wish that I would have taken the courage to seek a counselor's help, but I was young at the time and didn't understand things.

Therapist: Do you have 30 minutes a day when your roommate will be out?

Client: Yeah, our class schedules are a little different.

Therapist: Well then make it a part of your daily schedule and come back in a week. I

would really like to continue our work, like I said I know that this can be extremely difficult.

Client: Thanks for the help!

In the previous scenario:

The gender of the therapist was: Male _____ Female _____

The gender of the client was: Male _____ Female _____

Appendix H

Please imagine yourself as an objective observer of a therapy session between a therapist and a client. In the following scenario, a female therapist is working with a female client by the name of Bridgett. Bridgett has come to the University's Counseling Center to explore the concerns she has over the recent loss of her mother to cancer, and how this loss has been affecting her ability to attend to her classes, her grades, and her ability to cope.

(Female therapist/Female client – “Bridgett”)

Therapist: Hello Bridgett, so what brings you in?

Client: I'm not sure?

Therapist: What's on your mind?

Client: Oh, lots of things.

Therapist: Such as?

Client: School and all, my grades I don't know, I'm just tired, been pretty consumed and kind of confused.

Therapist: Confused about what?

Client: Well, family stuff.

Therapist: Mm hmm, what's going on with your family?

Client: Oh I don't know, where do I begin, there is so much...

Therapist: How about the beginning?

Client: Well, it's like this, my mom died six months ago. It was pretty sudden, she was doing great, healthy and all, until they found it?

Therapist: What did they find?

Client: A tumor, then she was gone, it was too fast. I still just can't believe it. There was

no warning.

Therapist: It took you by surprise, didn't it?

Client: Yeah, I'm just really struggling with everything.

Therapist: Tell me about how you are dealing with things now.

Client: Just trying to cope day by day.

Therapist: It's hard isn't it?

Client: (client nods), I'm just wanting to work through it, it's interfering with everything,

but I'm just having a hard time with it. You know when I was home, I could journal, do things my mom and I use to do together, stay in bed if I wanted, talk to family and friends.

Therapist: You've had a hard time doing those things here huh?

Client: Well it is hard to do these things with a roommate. You know

the other day, I had one of those really tough days. I had a really big exam and couldn't stop thinking of my mom. I probably flunked it! Not that it matters, I'll probably flunk out of the class anyway. Well anyway, I just got back to my room after the exam and I just wanted to be alone with my thoughts, but there she was, my roommate, had all of her friends over, watching some dumb movie. I couldn't exactly express myself there?

Therapist: That tough huh?

Client: Definitely. She doesn't even have a clue. I said something to her once about it,

when I first got to campus and she just changed the subject on me, talking about something insignificant. She has no clue, she comes from a picture perfect family.

Therapist: What do you wish you could have done?

Client: I just wish I could have had some time to myself. It's just been so hard, I'm going

through all of these changes and she is not here for me. She wasn't here to help me move into my dorm room like all of the other kids. It's not just the same with my dad.

Therapist: Sounds like coming to college has been a big transition for you that has been compounded by the recent loss of your mother. This must be an extremely difficult time for you?

Client: Yeah.

Therapist: You know Bridgett I had a really tough loss when I was fifteen years old, my mom left when my parents were going through a divorce. It was a really tough time for me. My parents weren't getting along and they were always fighting. I remember my mom yelling a lot and saying a lot of bad things. I'm just glad that it doesn't hurt anymore.

Client: I just wish she was here.

Therapist: What would you tell her?

Client: That I'm really angry, that I didn't want her to leave me and that I need her, especially with all of the changes occurring in my life.

Therapist: mmm hmm.

Client: What am I supposed to do?

Therapist: What would your mom tell you to do?

Client: Oh that's easy, she would know exactly what to do, she was a really strong person. She would tell me to not give up, to be strong.

Therapist: Does it help to think of how she would be encouraging to you now?

Client: Yeah, but it's not enough.

Therapist: But it helps some?

Client: Yes.

Therapist: Bridgett, I could tell you from my mom walking out on us that losing a parent through a divorce is extremely difficult and probably one of the hardest things that you could ever experience. But there are ways to make it easier such as what you just mentioned. After my mom left us I used to write her letters about the way that I was feeling, but I never had the courage to send them to her. Sometimes I wonder how she would have responded.

Client: But how do I cope when I am sharing a very small living space with a roommate who might as well come from the perfect family?

Therapist: That's a great question. Since this loss is so recent you will have some difficult times ahead of you. One thing that I think would help would be for us to continue our work together, but you still have to process on your own. Do you have any ideas as to get around the roommate issue?

Client: Not really, I was hoping you could help with that.

Therapist: Well here is an idea that worked for me, after my mom left I felt miserable.

Client: Tell me about it.

Therapist: I came to a point that I decided I didn't want to live in misery anymore. I was tired of everyone feeling sorry for me.

Client: But it's not like you can just forget that it happened.

Therapist: Exactly. So here is what I did. I would allow myself 30 minutes a day to be sad and grieve. I would do whatever it was that I felt I needed for those 30 minutes, then I would visualize myself putting away my pain on a shelf in my mind until the next day when I would pull it out again.

Client: And this really worked?

Therapist: Well to be honest, not every time but usually.

Client: Well I am willing to give anything a shot.

Therapist: Good, because that's essential, something that I wished I would have done right away. As a matter of fact, I wish that I would have taken the courage to seek a counselor's help, but I was young at the time and didn't understand things.

Therapist: Do you have 30 minutes a day when your roommate will be out?

Client: Yeah, our class schedules are a little different.

Therapist: Well then make it a part of your daily schedule and come back in a week. I would really like to continue our work, like I said I know that this can be extremely difficult.

Client: Thanks for the help!

In the previous scenario:

The gender of the therapist was: Male _____ Female _____

The gender of the client was: Male _____ Female _____

Appendix I

Please imagine yourself as an objective observer of a therapy session between a therapist and a client. In the following scenario, a male therapist is working with a female client by the name of Bridgett. Bridgett has come to the University's Counseling Center to explore the concerns she has over the recent loss of her mother to cancer, and how this loss has been affecting her ability to attend to her classes, her grades, and her ability to cope.

(Male therapist/Female client – “Bridgett”)

Therapist: Hello Bridgett, so what brings you in?

Client: I'm not sure?

Therapist: What's on your mind?

Client: Oh, lots of things.

Therapist: Such as?

Client: School and all, my grades I don't know, I'm just tired, been pretty consumed and kind of confused.

Therapist: Confused about what?

Client: Well, family stuff.

Therapist: Mm hmm, what's going on with your family?

Client: Oh I don't know, where do I begin, there is so much...

Therapist: How about the beginning?

Client: Well, it's like this, my mom died six months ago. It was pretty sudden, she was doing great, healthy and all, until they found it?

Therapist: What did they find?

Client: A tumor, then she was gone, it was too fast. I still just can't believe it. There was

no warning.

Therapist: It took you by surprise, didn't it?

Client: Yeah, I'm just really struggling with everything.

Therapist: Tell me about how you are dealing with things now.

Client: Just trying to cope day by day.

Therapist: It's hard isn't it?

Client: (client nods), I'm just wanting to work through it, it's interfering with everything,

but I'm just having a hard time with it. You know when I was home, I could journal, do things my mom and I use to do together, stay in bed if I wanted, talk to family and friends.

Therapist: You've had a hard time doing those things here huh?

Client: Well it is hard to do these things with a roommate. You know

the other day, I had one of those really tough days. I had a really big exam and couldn't stop thinking of my dad. I probably flunked it! Not that it matters, I'll probably flunk out of the class anyway. Well anyway, I just got back to my room after the exam and I just wanted to be alone with my thoughts, but there she was, my roommate, had all of her friends over, watching some dumb movie. I couldn't exactly express myself there?

Therapist: That tough huh?

Client: Definitely. She doesn't even have a clue. I said something to her once about it,

when I first got to campus and she just changed the subject on me, talking about something insignificant. She has no clue, she comes from a picture perfect family.

Therapist: What do you wish you could have done?

Client: I just wish I could have had some time to myself. It's just been so hard, I'm going

through all of these changes and she is not here for me. She wasn't here to help me move into my dorm room like all of the other kids. It's not just the same with my dad.

Therapist: Sounds like coming to college has been a big transition for you that has been compounded by the recent loss of your mom. This must be an extremely difficult time for you?

Client: Yeah.

Therapist: I can imagine that this is a very painful and difficult experience. When you lose a parent at a young age it can feel so unfair and wrong. Many college students who have lost a parent struggle with feeling as if they have lost their support base in life. They go through all kinds of feelings, sadness, anger, loneliness. When you lose a parent so young it can feel as if you are the only one dealing with this. As a result, students who lose a parent sometimes struggle with knowing how to cope with things given all of the changes in their life.

Client: I just wish she was here.

Therapist: What would you tell her?

Client: That I'm really angry, that I didn't want her to leave me and that I need her, especially with all of the changes occurring in my life.

Therapist: Mmm hmm.

Client: What am I supposed to do?

Therapist: What would your mom tell you to do?

Client: Oh that's easy, she would know exactly what to do, she was a really strong person. She would tell me to not give up, to be strong.

Therapist: Does it help to think of how she would be encouraging to you now?

Client: Yeah, but it's not enough.

Therapist: But it helps some?

Client: Yes.

Therapist: Often those going through these types of things really struggle with how to find relief. Frequently they might wonder what will work for them and whether it is enough. Relief is an element that is not always easy to find and one might question whether they have the strength to carry on.

Client: But how do I cope when I am sharing a very small living space with a roommate who might as well come from the perfect family?

Therapist: That's a great question. Since this loss is so recent you will have some difficult times ahead of you. One thing that I think would help would be for us to continue our work together, but you still have to process on your own. Do you have any ideas as to get around the roommate issue?

Client: Not really, I was hoping you could help with that.

Therapist: Well here is an idea that worked for another client that I was working with who after their mom died was really struggling and felt miserable about it.

Client: Tell me about it.

Therapist: They came to the point that they decided that they didn't want to live in misery anymore. They were tired of everyone feeling sorry for them.

Client: But it's not like they could have forget that it happened.

Therapist: Exactly. But here is what they did. They allowed themselves 30 minutes a day

to be sad and to grieve. Doing whatever it was that they needed to do for those 30 minutes, then they visualized themselves putting away the pain on a shelf in their mind until the next day when they would pull it out again.

Client: And this really worked?

Therapist: Well to be honest, they informed me that it did not work every time but usually.

Client: Well I am willing to give anything a shot.

Therapist: It sounds like you're committed to the process and willing to take some action. Things have probably added up. Sometimes, people never take these steps and continue to struggle with no relief in sight. But those who do seek relief can increase their chances in finding it.

Therapist: Do you have 30 minutes a day when your roommate will be out?

Client: Yeah, our class schedules are a little different.

Therapist: Well then make it a part of your daily schedule and come back in a week. I would really like to continue our work, like I said I know that this can be extremely difficult.

Client: Thanks for the help!

In the previous scenario:

The gender of the therapist was: Male _____ Female _____

The gender of the client was: Male _____ Female _____

Appendix J

Please imagine yourself as an objective observer of a therapy session between a therapist and a client. In the following scenario, a female therapist is working with a male client by the name of David. David has come to the University's Counseling Center to explore the concerns he has over the recent loss of his father to cancer, and how this loss has been affecting his ability to attend to his classes, his grades, and his ability to cope.

(Female therapist/Male client – “David”)

Therapist: Hello David, so what brings you in?

Client: I'm not sure?

Therapist: What's on your mind?

Client: Oh, lots of things.

Therapist: Such as?

Client: School and all, my grades I don't know, I'm just tired, been pretty consumed and kind of confused.

Therapist: Confused about what?

Client: Well, family stuff.

Therapist: Mm hmm, what's going on with your family?

Client: Oh I don't know, where do I begin, there is so much...

Therapist: How about the beginning?

Client: Well, it's like this, my dad died six months ago. It was pretty sudden, he was doing great, healthy and all, until they found it?

Therapist: What did they find?

Client: A tumor, then he was gone, it was too fast. I still just can't believe it. There was

no warning.

Therapist: It took you by surprise, didn't it?

Client: Yeah, I'm just really struggling with everything.

Therapist: Tell me about how you are dealing with things now.

Client: Just trying to cope day by day.

Therapist: It's hard isn't it?

Client: (client nods), I'm just wanting to work through it, it's interfering with everything,

but I'm just having a hard time with it. You know when I was home, I could journal, do things my dad and I use to do together, stay in bed if I wanted, talk to family and friends.

Therapist: You've had a hard time doing those things here huh?

Client: Well it is hard to do these things with a roommate. You know

the other day, I had one of those really tough days. I had a really big exam and couldn't stop thinking of my dad. I probably flunked it! Not that it matters, I'll probably flunk out of the class anyway. Well anyway, I just got back to my room after the exam and I just wanted to be alone with my thoughts, but there he was, my roommate, had all of his friends over, watching some dumb movie. I couldn't exactly express myself there?

Therapist: That tough huh?

Client: Definitely. He doesn't even have a clue. I said something to him once about it,

when I first got to campus and he just changed the subject on me, talking about something insignificant. He has no clue, she comes from a picture perfect family.

Therapist: What do you wish you could have done?

Client: I just wish I could have had some time to myself. It's just been so hard, I'm going

through all of these changes and he is not here for me. He wasn't here to help me move into my dorm room like all of the other kids. It's not just the same with my dad.

Therapist: Sounds like coming to college has been a big transition for you that has been compounded by the recent loss of your dad. This must be an extremely difficult time for you?

Client: Yeah.

Therapist: I can imagine that this is a very painful and difficult experience. When you lose a parent at a young age it can feel so unfair and wrong. Many college students who have lost a parent struggle with feeling as if they have lost their support base in life. They go through all kinds of feelings, sadness, anger, loneliness. When you lose a parent so young it can feel as if you are the only one dealing with this. As a result, students who lose a parent sometimes struggle with knowing how to cope with things given all of the changes in their life.

Client: I just wish he was here.

Therapist: What would you tell him?

Client: That I'm really angry, that I didn't want him to leave me and that I need him, especially with all of the changes occurring in my life.

Therapist: Mmm hmm.

Client: What am I supposed to do?

Therapist: What would your dad tell you to do?

Client: Oh that's easy, he would know exactly what to do, he was a really strong person. He would tell me to not give up, to be strong.

Therapist: Does it help to think of how he would be encouraging to you now?

Client: Yeah, but it's not enough.

Therapist: But it helps some?

Client: Yes.

Therapist: Often those going through these types of things really struggle with how to find relief. Frequently they might wonder what will work for them and whether it is enough. Relief is an element that is not always easy to find and one might question whether they have the strength to carry on.

Client: But how do I cope when I am sharing a very small living space with a roommate who might as well come from the perfect family?

Therapist: That's a great question. Since this loss is so recent you will have some difficult times ahead of you. One thing that I think would help would be for us to continue our work together, but you still have to process on your own. Do you have any ideas as to get around the roommate issue?

Client: Not really, I was hoping you could help with that.

Therapist: Well here is an idea that worked for another client that I was working with who after their dad died was really struggling and felt miserable about it.

Client: Tell me about it.

Therapist: They came to the point that they decided that they didn't want to live in misery anymore. They were tired of everyone feeling sorry for them.

Client: But it's not like they could have forget that it happened.

Therapist: Exactly. But here is what they did. They allowed themselves 30 minutes a day

to be sad and to grieve. Doing whatever it was that they needed to do for those 30 minutes, then they visualized themselves putting away the pain on a shelf in their mind until the next day when they would pull it out again.

Client: And this really worked?

Therapist: Well to be honest, they informed me that it did not work every time but usually.

Client: Well I am willing to give anything a shot.

Client: It sounds like you're committed to the process and willing to take some action. Things have probably added up. Sometimes, people never take these steps and continue to struggle with no relief in sight. But those who do seek relief can increase their chances in finding it.

Therapist: Do you have 30 minutes a day when your roommate will be out?

Client: Yeah, our class schedules are a little different.

Therapist: Well then make it a part of your daily schedule and come back in a week. I would really like to continue our work, like I said I know that this can be extremely difficult.

Client: Thanks for the help!

In the previous scenario:

The gender of the therapist was: Male _____ Female _____

The gender of the client was: Male _____ Female _____

Appendix K

Please imagine yourself as an objective observer of a therapy session between a therapist and a client. In the following scenario, a male therapist is working with a male client by the name of David. David has come to the University's Counseling Center to explore the concerns he has over the recent loss of his father to cancer, and how this loss has been affecting his ability to attend to his classes, his grades, and his ability to cope.

(Male therapist/Male client – “David”)

Therapist: Hello David, so what brings you in?

Client: I'm not sure?

Therapist: What's on your mind?

Client: Oh, lots of things.

Therapist: Such as?

Client: School and all, my grades I don't know, I'm just tired, been pretty consumed and kind of confused.

Therapist: Confused about what?

Client: Well, family stuff.

Therapist: Mm hmm, what's going on with your family?

Client: Oh I don't know, where do I begin, there is so much...

Therapist: How about the beginning?

Client: Well, it's like this, my dad died six months ago. It was pretty sudden, he was doing great, healthy and all, until they found it?

Therapist: What did they find?

Client: A tumor, then he was gone, it was too fast. I still just can't believe it. There was

no warning.

Therapist: It took you by surprise, didn't it?

Client: Yeah, I'm just really struggling with everything.

Therapist: Tell me about how you are dealing with things now.

Client: Just trying to cope day by day.

Therapist: It's hard isn't it?

Client: (client nods), I'm just wanting to work through it, it's interfering with everything,

but I'm just having a hard time with it. You know when I was home, I could journal, do things my dad and I use to do together, stay in bed if I wanted, talk to family and friends.

Therapist: You've had a hard time doing those things here huh?

Client: Well it is hard to do these things with a roommate. You know

the other day, I had one of those really tough days. I had a really big exam and couldn't stop thinking of my dad. I probably flunked it! Not that it matters, I'll probably flunk out of the class anyway. Well anyway, I just got back to my room after the exam and I just wanted to be alone with my thoughts, but there he was, my roommate, had all of his friends over, watching some dumb movie. I couldn't exactly express myself there?

Therapist: That tough huh?

Client: Definitely. He doesn't even have a clue. I said something to him once about it,

when I first got to campus and he just changed the subject on me, talking about something insignificant. He has no clue, he comes from a picture perfect family.

Therapist: What do you wish you could have done?

Client: I just wish I could have had some time to myself. It's just been so hard, I'm going

through all of these changes and he is not here for me. He wasn't here to help me move into my dorm room like all of the other kids. It's not just the same with my mom.

Therapist: Sounds like coming to college has been a big transition for you that has been compounded by the recent loss of your dad. This must be an extremely difficult time for you?

Client: Yeah.

Therapist: I can imagine that this is a very painful and difficult experience. When you lose a parent at a young age it can feel so unfair and wrong. Many college students who have lost a parent struggle with feeling as if they have lost their support base in life. They go through all kinds of feelings, sadness, anger, loneliness. When you lose a parent so young it can feel as if you are the only one dealing with this. As a result, students who lose a parent sometimes struggle with knowing how to cope with things given all of the changes in their life.

Client: I just wish he was here.

Therapist: What would you tell him?

Client: That I'm really angry, that I didn't want him to leave me and that I need him, especially with all of the changes occurring in my life.

Therapist: Mmm hmm.

Client: What am I supposed to do?

Therapist: What would your dad tell you to do?

Client: Oh that's easy, he would know exactly what to do, he was a really strong person. He would tell me to not give up, to be strong.

Therapist: Does it help to think of how he would be encouraging to you now?

Client: Yeah, but it's not enough.

Therapist: But it helps some?

Client: Yes.

Therapist: Often those going through these types of things really struggle with how to find relief. Frequently they might wonder what will work for them and whether it is enough. Relief is an element that is not always easy to find and one might question whether they have the strength to carry on.

Client: But how do I cope when I am sharing a very small living space with a roommate who might as well come from the perfect family?

Therapist: That's a great question. Since this loss is so recent you will have some difficult times ahead of you. One thing that I think would help would be for us to continue our work together, but you still have to process on your own. Do you have any ideas as to get around the roommate issue?

Client: Not really, I was hoping you could help with that.

Therapist: Well here is an idea that worked for another client that I was working with who after their dad died was really struggling and felt miserable about it.

Client: Tell me about it.

Therapist: They came to the point that they decided that they didn't want to live in misery anymore. They were tired of everyone feeling sorry for them.

Client: But it's not like they could have forget that it happened.

Therapist: Exactly. But here is what they did. They allowed themselves 30 minutes a day

to be sad and to grieve. Doing whatever it was that they needed to do for those 30 minutes, then they visualized themselves putting away the pain on a shelf in their mind until the next day when they would pull it out again.

Client: And this really worked?

Therapist: Well to be honest, they informed me that it did not work every time but usually.

Client: Well I am willing to give anything a shot.

Therapist: It sounds like you're committed to the process and willing to take some action. Things have probably added up. Sometimes, people never take these steps and continue to struggle with no relief in sight. But those who do seek relief can increase their chances in finding it.

Therapist: Do you have 30 minutes a day when your roommate will be out?

Client: Yeah, our class schedules are a little different.

Therapist: Well then make it a part of your daily schedule and come back in a week. I would really like to continue our work, like I said I know that this can be extremely difficult.

Client: Thanks for the help!

In the previous scenario:

The gender of the therapist was: Male _____ Female _____

The gender of the client was: Male _____ Female _____

Appendix L

Please imagine yourself as an objective observer of a therapy session between a therapist and a client. In the following scenario, a female therapist is working with a female client by the name of Bridgett. Bridgett has come to the University's Counseling Center to explore the concerns she has over the recent loss of her mother to cancer, and how this loss has been affecting her ability to attend to her classes, her grades, and her ability to cope.

(Female therapist/Female client – “Bridgett”)

Therapist: Hello Bridgett, so what brings you in?

Client: I'm not sure?

Therapist: What's on your mind?

Client: Oh, lots of things.

Therapist: Such as?

Client: School and all, my grades I don't know, I'm just tired, been pretty consumed and kind of confused.

Therapist: Confused about what?

Client: Well, family stuff.

Therapist: Mm hmm, what's going on with your family?

Client: Oh I don't know, where do I begin, there is so much...

Therapist: How about the beginning?

Client: Well, it's like this, my mom died six months ago. It was pretty sudden, she was doing great, healthy and all, until they found it?

Therapist: What did they find?

Client: A tumor, then she was gone, it was too fast. I still just can't believe it. There was

no warning.

Therapist: It took you by surprise, didn't it?

Client: Yeah, I'm just really struggling with everything.

Therapist: Tell me about how you are dealing with things now.

Client: Just trying to cope day by day.

Therapist: It's hard isn't it?

Client: (client nods), I'm just wanting to work through it, it's interfering with everything,

but I'm just having a hard time with it. You know when I was home, I could journal, do things my mom and I use to do together, stay in bed if I wanted, talk to family and friends.

Therapist: You've had a hard time doing those things here huh?

Client: Well it is hard to do these things with a roommate. You know

the other day, I had one of those really tough days. I had a really big exam and couldn't stop thinking of my mom. I probably flunked it! Not that it matters, I'll probably flunk out of the class anyway. Well anyway, I just got back to my room after the exam and I just wanted to be alone with my thoughts, but there she was, my roommate, had all of her friends over, watching some dumb movie. I couldn't exactly express myself there?

Therapist: That tough huh?

Client: Definitely. She doesn't even have a clue. I said something to her once about it,

when I first got to campus and she just changed the subject on me, talking about something insignificant. She has no clue, she comes from a picture perfect family.

Therapist: What do you wish you could have done?

Client: I just wish I could have had some time to myself. It's just been so hard, I'm going

through all of these changes and she is not here for me. She wasn't here to help me move into my dorm room like all of the other kids. It's not just the same with my dad.

Therapist: Sounds like coming to college has been a big transition for you that has been compounded by the recent loss of your mom. This must be an extremely difficult time for you?

Client: Yeah.

Therapist: I can imagine that this is a very painful and difficult experience. When you lose a parent at a young age it can feel so unfair and wrong. Many college students who have lost a parent struggle with feeling as if they have lost their support base in life. They go through all kinds of feelings, sadness, anger, loneliness. When you lose a parent so young it can feel as if you are the only one dealing with this. As a result, students who lose a parent sometimes struggle with knowing how to cope with things given all of the changes in their life.

Client: I just wish she was here.

Therapist: What would you tell her?

Client: That I'm really angry, that I didn't want her to leave me and that I need her, especially with all of the changes occurring in my life.

Therapist: Mmm hmm.

Client: What am I supposed to do?

Therapist: What would your mom tell you to do?

Client: Oh that's easy, she would know exactly what to do, she was a really strong person. She would tell me to not give up, to be strong.

Therapist: Does it help to think of how she would be encouraging to you now?

Client: Yeah, but it's not enough.

Therapist: But it helps some?

Client: Yes.

Therapist: Often those going through these types of things really struggle with how to find relief. Frequently they might wonder what will work for them and whether it is enough. Relief is an element that is not always easy to find and one might question whether they have the strength to carry on.

Client: But how do I cope when I am sharing a very small living space with a roommate who might as well come from the perfect family?

Therapist: That's a great question. Since this loss is so recent you will have some difficult times ahead of you. One thing that I think would help would be for us to continue our work together, but you still have to process on your own. Do you have any ideas as to get around the roommate issue?

Client: Not really, I was hoping you could help with that.

Therapist: Well here is an idea that worked for another client that I was working with who after their mom died was really struggling and felt miserable about it.

Client: Tell me about it.

Therapist: They came to the point that they decided that they didn't want to live in misery anymore. They were tired of everyone feeling sorry for them.

Client: But it's not like they could have forget that it happened.

Therapist: Exactly. But here is what they did. They allowed themselves 30 minutes a day

to be sad and to grieve. Doing whatever it was that they needed to do for those 30 minutes, then they visualized themselves putting away the pain on a shelf in their mind until the next day when they would pull it out again.

Client: And this really worked?

Therapist: Well to be honest, they informed me that it did not work every time but usually.

Client: Well I am willing to give anything a shot.

Therapist: It sounds like you're committed to the process and willing to take some action. Things have probably added up. Sometimes, people never take these steps and continue to struggle with no relief in sight. But those who do seek relief can increase their chances in finding it.

Therapist: Do you have 30 minutes a day when your roommate will be out?

Client: Yeah, our class schedules are a little different.

Therapist: Well then make it a part of your daily schedule and come back in a week. I would really like to continue our work, like I said I know that this can be extremely difficult.

Client: Thanks for the help!

In the previous scenario:

The gender of the therapist was Male _____ Female _____

The gender of the client was: Male _____ Female _____

Appendix M

Research Procedure Form

You are being asked to participate in a research study which should take no longer than 20 minutes. Your involvement in this study will involve your being asked to complete a brief demographic form, to complete the reading of a brief therapy transcript, and to complete an instrument of the working alliance over the transcript which you had just read. Initially, you will be asked to read and sign a form of informed consent. Participation is optional and you may withdraw or decline from this research project at any time. If you are considered a minor, 17 years of age or younger (State of Kansas), age 18 or younger (State of Nebraska) you will not be permitted to participate in this research study.

Appendix N

KANSAS STATE UNIVERSITY INFORMED CONSENT TEMPLATE

PROJECT TITLE: Self-Disclosure Type and Therapy Gender Arrangement Influences on the Working Alliance

APPROVAL DATE OF PROJECT: 11-13-06 EXPIRATION DATE OF PROJECT: _____

PRINCIPAL INVESTIGATOR: CO-INVESTIGATOR(S): Steve Benton, Ph.D., Department of Counseling and Educational Psychology (principle investigator); Paul Stevens, student (co-investigator)

CONTACT AND PHONE FOR ANY PROBLEMS/QUESTIONS: Paul Stevens/stevensp@ksu.edu/402-310-7811

IRB CHAIR CONTACT/PHONE INFORMATION: Rick Scheidt (785) 532-3224

PURPOSE OF THE RESEARCH: The purpose of this research is to investigate therapeutic influences on the observers' perception of the counseling process.

PROCEDURES OR METHODS TO BE USED: You will be asked to read a counseling transcript followed by the completion of a questionnaire assessing your perceptions of the therapy process. An accompanying brief demographic form for completion will also be provided. The overall process should take no more than 20 minutes of your time.

ALTERNATIVE PROCEDURES OR TREATMENTS, IF ANY, THAT MIGHT BE ADVANTAGEOUS TO SUBJECT:

None

LENGTH OF STUDY: 20 minutes

RISKS ANTICIPATED: If a participant has experiences similar to the issues described in the therapy transcript, he or she may experience some discomfort by the reading of the transcript. It is expected that the risk of discomfort during this study would be comparable to that of daily life (e.g., watching television or engaging in conversation with a

friend).

BENEFITS ANTICIPATED:

1. Benefits:
 - a. The benefits to participants include the acquisition of experience and insight into social science research and with the therapeutic process.
 - b. The benefits to society include providing additional information about therapeutic process, and when combined with other research findings could act as a guide to the theory and practice of psychotherapy.

EXTENT OF CONFIDENTIALITY:

The following study has been designed to insure your confidentiality. The study will not in anyway be asking you for any identifying demographic information which may link you to this study (e.g. name, social security number, address, or phone number). Your course instructor will know that you have earned extra credit only through your participation in this study or through an identified alternative means.

PARENTAL APPROVAL FOR MINORS:

If you are considered a minor, 17 years of age or younger (State of Kansas), age 18 or younger (State of Nebraska) you will not be permitted to participate in this research.

TERMS OF PARTICIPATION: I understand this project is research, and that my participation is completely voluntary. I also understand that if I decide to participate in this study, I may withdraw my consent at any time, and stop participating at any time without explanation, penalty, or loss of benefits, or academic standing to which I may otherwise be entitled.

I verify that my signature below indicates that I have read and understand this consent form, and willingly agree to participate in this study under the terms described, and that my signature acknowledges that I have received a signed and dated copy of this consent form.

(Remember that it is a requirement for the P.I. to maintain a signed and dated copy of the same consent form signed and kept by the participant)

Participant Name: _____

A. _____

B. Participant Signature: _____

Date: _____

Witness to Signature: (project staff) _____

Date: _____

Appendix O

Demographic Form

Age:

Sex:

College

(Please circle the college in which you are enrolled)

Agriculture Architecture Arts & Sciences Business Administration Education
Engineering Human Ecology Aviation/Technical Graduate School Other
Class

(Please circle the class you are in)

Freshman Sophomore Junior Senior Grad/Professional

Ethnicity

(Please circle your ethnicity)

African American Asian/Pacific Islander Caucasian Hispanic/Latino
Native American/Alaska Native Interracial or mixed Other

Appendix P

SIMON FRASER UNIVERSITY



Burnaby British Columbia, Canada V5A 1S6

Mr. Paul Stevens

Kansas State University

7100 Holmes Park Road #118

Lincoln NE.

68506

U.S. November 19, 2006

LIMITED COPYRIGHT LICENSE (ELECTRONIC) # 20061911.0

Dear Mr. Stevens

You have permission to use the Working Alliance Inventory (WAI) for the investigation: "Self-Disclosure Type and Therapy Gender Arrangement Influences on the Working Alliance."

This limited copyright release extends to all forms of the WAI for which I hold copyright privileges, but limited to use of the inventory for not-for-profit research, and does not include the right to publish or distribute the instrument(s) in any form.

I would appreciate if you shared the results of your research with me when your work is completed so I may share this information with other researchers who might wish to use the WAI. If I can be of further help, do not hesitate to contact me.

Sincerely,

Dr. Adam O. Horvath Professor Faculty of Education and Department of Psychology
Ph# (604) 291-3624 Fax: (604) 291-3203 e-mail: Horvath@sfu.ca Internet:
<http://www.educ.sfu.ca/alliance/allianceA>

A handwritten signature in black ink, appearing to read "Adam O. Horvath".

Appendix Q

Self-Disclosure Influences Study

Debriefing

The study in which you just participated is an effort to look more closely into some of the therapeutic factors which are likely to impact how a therapist and a psychotherapy session are viewed by the observer. In particular, this study explores the impact of the gender composition of the therapy relationship, as well as varied forms of self-disclosure upon the working alliance.

As it is used in this study, the working alliance refers to the relationship that the client and the therapist have formed. An effective working alliance is denoted by the client's "and" the therapist's agreement on the over-arching goals of therapy, the specific tasks to be attended to in each session, as well as the bond or connection that both participants share. Generally speaking, the stronger the working alliance, the greater the perceived effectiveness of the counseling session held by the observer, be it the client, the therapist, or the outside observer.

Self-disclosure has both its advocates and its critics, often predicated upon the therapist's theoretical orientation, with psychoanalytic therapists disclosing the least and humanistic therapists disclosing the most (Simon, 1988). During this study you viewed just one of 12 therapy transcripts identical in all aspects, except for the type of self-disclosure used (similar, dissimilar, and no disclosure) as well as for the manipulation of the gender arrangement (therapist, client) of the therapy relationship

Only one form of the therapist's self-disclosure was utilized for each one of the scripts. In the similar disclosure condition, the therapist revealed on three occasions, similar struggles to those shared by the client, whereas in the dissimilar disclosure condition, the therapist revealed on three occasions struggles unrelated to what the client had said. In the no disclosure condition,

the counselor made no self-disclosures, but instead responded with statements of empathy on three separate occasions in replacement of the therapist self-disclosures. It is expected that therapists who utilized similar self-disclosures will be assigned greater working alliance ratings by observers than by observers of therapists who utilized dissimilar and no forms of self-disclosure.

In terms of the manipulated gender arrangement of the therapy relationship (e.g. male therapist/male client, female therapist/female client, male therapist/female client, female therapist/male client), you observed only one of the four possible combinations in tandem with one of the three forms of self-disclosure. It is expected that the gender composition of the therapy relationship will influence observer ratings of the working alliance.

In terms of your participation in this study, it is expected that you will not suffer any adverse effects. However, if you do experience any distress that you believed has been caused by participating, please contact the primary investigator with your concern. In addition, if you have any questions regarding the study that was not addressed above, please feel free to email the investigator as well. Thank you for your time and effort.

Paul Stevens (Primary Investigator)
7100 Holmes Park Road #118
Lincoln, NE. 68506
Email: stevensp@ksu.edu
Phone: (402) 310-7811

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Dept. of Counseling & Ed. Psych
Kansas State University
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