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Gender differences and depression in self-disclosure on the therapeutic relationship

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GENDER DIFFERENCES AND DEPRESSION IN SELF-DISCLOSURE ON THE THERAPEUTIC RELATIONSHIP

by
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Dedication

This manuscript is dedicated to my boyfriend, Jesse Farrell. Your unconditional love and

support during this process and academic experience made it possible for me to fulfill my

dreams. I am forever grateful.

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Abstract

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The counseling relationship is a major factor in promoting change from the client

in the therapeutic relationship. Additional factors contributing to or hindering this

relationship including gender, depressive symptomology, and disclosure tendency,

collectively require further attention to facilitate improved treatment outcomes in

counseling. Male and female college students ($N = 212$) completed measures that

assessed depression symptomology and disclosure tendency. It was hypothesized that

female college students would engage in greater levels of self-disclosure than male

students and that greater depressive symptomology would equate to a lesser degree of

disclosure tendency. The employed ANOVA model found no interaction between gender,

depression, and disclosure; however, results partially supported the hypotheses. Female

college students engaged in greater levels of self-disclosure compared to male students.

Greater depressive symptomology however, equated to greater disclosure among both

male and female participants. Limitations, directions for future research, and implications

of finding were discussed.

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Chapter 1

Introduction

The purpose of the counseling relationship is to enact therapeutic change from the client. This relationship between the client and the counselor in the therapeutic dynamic, facilitates personal growth, emotional, behavioral, and/or cognitive change. The counseling relationship acts as a stronghold to facilitate feelings of support and understanding from the client (Hill, 2009). Research states that the therapeutic relationship is built upon the working alliance, established between the client and the counselor (Gelso, 1994). Referring to the quality of the client and counselor interaction in regards to an agreement of treatment, the working alliance is a major factor in promoting change (Bordin, 1979). As a result, this alliance is a significant predictor of treatment outcomes (Barber, 2000; Hill, 2009; Horvath, 1991; Horvath, 2002). Consequently, the therapeutic relationship has been a primary focus among empirical studies over the past few decades (Gatson, 1990). Focusing on additional factors contributing or hindering this relationship has allowed research the opportunity to evaluate the role of the counseling dynamic (Strong, 1968).

In order for this counseling relationship to be formed, a connection between the client and counselor must allow for a flow of information in the relationship. Initiated based on the counselor's ability to provoke the client's trust, in both the counselor and the counseling relationship this trust is the basis of the therapeutic relationship (Thomas, 2011). As a key predictor in the successful treatment outcomes of counseling, the formation of trust in the therapeutic relationship brings about feelings of safety, support, respect, value, and acceptance (Friedlander, 1970; Hill, 2009).

Trust is considered one of the most crucial components in the beginning stages of counseling. Change cannot occur until the client is able to open themselves up intimately and vulnerably to the counselor (Fong, 1983). This vulnerability facilitates personal exploration and thereby facilitating change and treatment outcomes. While the criterion and personal significance of trust is subjective, trust is dependent upon the perception of the individual to be without personal gain, at the expense of another (Strong, 1969). It is the expectation of the trusted individual to behave in a manner that is beneficial (Thom, 2011), forthright (Fong, 1983) and conducive to the formulation of goals (Gibb, 1964). In such a trusting setting or relationship, it is imperative that rapport is developed and established. As a result of the established trust between the client and counselor, treatment outcomes in counseling are impacted (Norcross, 2002).

Unlike friendships or relationships in everyday settings, the counseling relationship functions on a one-sided plane. A client seeking counseling is the sole focus in this dynamic, requiring great trust on behalf of the client. Based on this unique dynamic, trust is established as a client seeks out the reassurance that the counselor is trustworthy, and therefore deserving of their emotional investment (Fong, 1983). This trusting dynamic supports the development of therapeutic rapport in the counseling relationship. Rapport, or the atmosphere of understanding and respect, is a reflection of the level of trust shared between the client and counselor (Hill, 2009; Thomas, 2011). In a therapeutic relationship promoting personal growth, it is imperative that rapport is developed and maintained. The presence of rapport in a counseling relationship influences a client's inclination to share and reveal information about their true selves (Norcross, 2012). This bond facilitates emotional security needed to facilitate intimate

acts of disclosure. This nurtured relationship allows personal information, beliefs, and emotions to be freely expressed.

1.1 Self-Disclosure in the Therapeutic Relationship

Honest and forthcoming accounts of emotions and beliefs contribute to the development of relational trust. The act of sharing information deemed self-disclosure, has been defined as the content of which individuals verbally reveal about themselves to others (Derlega, 1993). Including thoughts, feelings, and experiences, self-disclosure is the revealing of reactions and the admission of information (Johnson, 1972). Self-disclosure in the counseling relationship intensifies and deepens the working alliance leading to a better understanding of the self and therefore treatment outcomes (Ziv-Beiman, 2013). Similar to the role of trust in the development of rapport, self-disclosure plays a role in the healthy development of rapport, and the establishment of the counseling relationship (Foubert, 1996).

Without disclosure in therapy, treatment outcomes are impacted (Norcross, 2002). While the development of effective methods to facilitate positive treatment outcomes serve as a goal in therapy, it is imperative that rapport be established giving way to therapeutic disclosure. Laying the foundation for the working alliance, disclosure strengthens the bond between the client and the counselor.

1.2 Self-Disclosure and Gender

An additional contributing factor to the foundation of the working alliance includes the added element of gender differences of the client. Research has consistently reported gender differences associated in mental health with prevalence rates of diagnosis (Schwartz, 2011). The Diagnostic and Statistical Manual of Mental Disorders [DSM]

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provides markedly different prevalence rates in gender, exhibited throughout the included psychiatric disorders (American Psychiatric Association, 2000). Considering that men and women are biologically different, differences of behavior and emotional regulation vary as well by gender and by individual. Gender differences are apparent in help-seeking behaviors in the counseling setting as relationships characterized by women are shaped around more intimate acts, including those of self-disclosure and emotional support (Reis, 1998; Schwartz, 2011).

Research surrounding the impact of gender differences of disclosure in the counseling relationship have provided contradictory results. For example, Chaudhuir (2012), has indicated no significant differences in disclosure tendencies between males and females, whereas Dindia (1992), supports evidence that women consistently disclose more often than men disclose. Such conflicting results limit the understanding of the role that gender plays in disclosure, and therefore the counseling relationship. Outside of the counseling dynamic, evidence suggests that women disclose more often than men (Chaudhuir, 2012). Based on similarities shared between the client and the counselor, evidence suggests that individuals are more likely to disclose personal information to those similar, or who share similar experiences (Kito, 2005). Such shared experiences or characteristics, allows the barriers in counseling to dissipate thereby improving the working alliance.

1.3 Self-Disclosure and Depression

According to the National Institute of Mental Health [NIMH] (2013), it is estimated that 26.2% of the population suffers from a mental health disorder. This statistic equates to one in four, or roughly 57.7 million individuals. As the leading cause

of disability in the U.S., one of the most common mental health disorders are mood disorders, affecting approximately 9.5% of the population, or roughly 20.9 million individuals (NIMH, 2013). Such mood disorders include depressive disorders such as Major Depressive Disorder, Dysthymic Disorder and Bipolar Disorder (APA, 2000). Focusing specifically on the prevalence of Major Depressive Disorder [MDD], 6.7% or roughly 14.8 million individuals, are affected by depression with a greater prevalence among women (NIMH, 2013).

Research aimed at depression among college students has found that 30% of college students reported "feeling so depressed that it was difficult to function" at one point in the past year (NIMH, 2012). Depression in the college population is one of the most common risk factors for suicide (Bauer, 2013), as the third leading cause of death among 18-24 year olds in the U.S. (Centers for Disease Control and Prevention, 2013). Based on the severity of consequences associated with this prominent mental health disorder, a college population serves to profit substantially from the benefits associated with a greater understanding of the counseling relationship.

Substantial health benefits have been found to occur as a result of disclosure in the therapeutic relationship (Jourard, 1971). Disclosure has been found to trigger a decrease in depression (Frattaroli, 2006), reduce intrusive thoughts (Lepore, 2000) and decrease emotional intensity (Zech, 2005). In relation to depressive symptomology, higher levels of depressive symptoms have been found to equate to less emotional disclosure (Garrison, 2012). In therapy, research states that clients with mood disorders typically avoid personal or emotional disclosure (Kahn, 2009). By reducing the tendency

for disclosure, those suffering from depression are thereby negatively influenced by the working alliance.

1.4 Purpose of the Present Study

The purpose of the present study was to examine differences in disclosure tendencies between male and female college students. Based on the research surrounding disclosure, further examination on gender differences and the presence of depressive symptomology was required. Expanding to the literature, it was necessary to study the relationship between gender, disclosure and depression. An awareness of how these factors contribute to therapeutic growth was the primary goal for the study so that improved treatment outcomes may be achieved in the counseling setting.

The current study predicted that female college students would engage in greater levels of self-disclosure than male students. It was also predicted that in treatment outcomes those experiencing greater depressive symptomology would experience a lesser degree of disclosure tendencies, compared to those experiencing minimal depressive symptomology. Female students with minimal depressive symptomology were thus predicted to disclose more so than male students with severe depressive symptomology.

Chapter 2

Method

2.1 Participants

A total of 212 college students from a mid-sized University in the northeastern United States completed the study. The mean age of the participants at the time they completed the study was 19.83 ($SD = 2.57$, range 18-45). Demographic information pertaining to participant's ethnicity/race endorsed White/Non-Hispanic ($N = 152$, 71.7%), African American ($N = 23$, 10.8%), Hispanic/Latino/Latina ($N = 24$, 11.3%), Asian/Pacific Islander ($N = 7$, 3.3%), Native American ($N = 1$, .5%), and other ($N = 5$, 2.2%). Half of the participants were first year students ($N = 108$, 50.9%), sophomores ($N = 46$, 21.7%), juniors ($N = 38$. 17.9%), seniors ($N = 18$, 8.5%) and graduate students ($N = 2$, .9%), at the time of the survey.

2.2 Materials

Participants completed a multiple assessment survey, consisting of the Beck Depression Inventory (Beck, Steer, & Brown, 1996), the Distress Disclosure Index (Kahn, 2001), and the Individualized Trust Scale (Wheeless, 1977). A demographic questionnaire assessing age, race, academic rank, and counseling experience was also completed.

Depressive Symptomology. The Beck Depression Inventory II (BDI-II) (Beck, 1996), was used to establish the presence of depressive symptomology of the participant. Consisting of 21 questions, participants selected a statement that best reflected the way they have felt in the past two weeks. Evaluated areas included changes in appetite, agitation, loss of interest, self-dislike, pessimism, crying and suicidal thoughts. The BDI

is aligned with the criterion needed to meet diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) for Major Depressive Disorder or Mood Disorders (Whiston, 2009). Utilizing a 4 point Likert scale, ranging from 0-3, presented with each statement participants were prompted to identified with statements including "I do not feel sad", "I have failed more than I should have", "I would like to kill myself", and "I have lost interest in sex completely". Selections were summed and interpreted based on their level of severity, thus providing a symptom severity index of depression. Falling between 0-13 was considered minimal range, 14-19 mild range, 20-28 moderate and 29-63 severe (Beck, 1996). An overall coefficient alpha of .92 for the BDI has been shown throughout the research, as well as strong support for the instrument's construct validity (Whiston, 2009).

Disclosure Tendency. The Distress Disclosure Index (DDI) (Kahn, 2001), was utilized to determine the tendency for disclosure necessary to the counseling treatment. This measure consisted of 12 questions requiring the participant to indicate the extent to which they agreed or disagreed with a given statement. Participants were asked to indicate their tendency to disclose verses conceal personally distressing information. The rating of each statement was scored on a 5 point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). Ratings were assigned to statements including "When I feel upset, I usually confide in my friends", "When I feel depressed or sad, I tend to keep those feelings to myself" and "I am willing to tell others my distressing thoughts". Selections made were summed with consideration for revised scoring with a maximum possible disclosure score of 36 and the minimum score 12. Higher summed scores indicated a higher disclosure distress tendency, while lower scores indicated greater

concealment. The test-retest reliability correlation coefficient for this measure has been shown as .80, with a coefficient alpha ranging from .92 to .95 (Kahn, 2001). Good convergent validity with gender has also been established (Kahn, 2001).

Individualized Trust. The Individualized Trust Scale (ITS) (Wheeless, 1977) assessed desirable characteristics of a trusted individual, pertinent to the counseling relationship. A 15 item semantic differential-type instrument, required the participant to select a numbered cell ranging from 1 to 7 based on the desired characteristic. On opposite ends of the cell range were descriptive synonyms or characteristics associated with trust including trustworthy or untrustworthy, honest or dishonest, sincere or insincere, and tricky or straightforward. Selections were summed with a maximum possible score of 105 (15x7) and the minimum score 15 (15x1), the greater the score assigned the greater the trust for the target individual. The internal consistent as measured by Cronbach's alpha has been shown between .91and .93, with a split half reliability of .92 (Wheeless, 1984).

2.3 Procedure

Approval for the study was obtained from the Rowan University Institutional Review Board. Participants were male and female students recruited via SONA, the Rowan psychology department's electronic student participant pool, to the study titled "Gender Differences in the Therapeutic Relationship." Participants electronically signed an informed consent detailing the purpose of the present study, confidentiality, risks and benefits of the study, and resources for psychological counseling if needed. With obtained consent, participants completed the demographic questionnaire, the Beck Depression Inventory (BDI), the Distress Disclosure Index (DDI), and the Individualized

Trust Scale (ITS). A debriefing form was provided at the conclusion of the study with additional resources. Psychology research credit was administered to students for their participation.

Chapter 3

Results

3.1 Preliminary Analyses

Data were collected in the Spring 2014. Surveys were completed by 227 students enrolled in Essentials of Psychology course at Rowan University. Of these collected surveys 15 were eliminated from the data due to incomplete information in which half of the 72 questions were left unanswered. Additional data was eliminated if it did not meet the average time of completion for the surveys which was 3.5 minutes in length. A total number of 212 surveys met this criteria. Ninety-nine (46.77%) were male participants, 109 (51.4%) were female participants and 4 (1.9%) identified as other for gender identifiers, with age *(M = 19.83, SD = 2.57)*.

3.2 Disclosure

Descriptive statistics analysis endorsed male disclosure *(M = 28.34, SD =1.5)* and female disclosure *(M = 30.02, SD =2.2)* compared to a total maximum disclosure tendency score with a mean of 36.

3.3 Depression

Depression severity was coded into four subjective rating categories based scoring of The Beck Depression Inventory II (BDI-II): 0-13 minimal, 14-19 mild, 20-28 moderate, and 29-63 severe depressive symptomology. Descriptive statistics endorsed 7 (3.3%) minimal depressive symptomology, 4 (1.9%) mild depressive, 89 (42%) moderate depressive symptomology and 107 (50.5%) severe depressive symptomology.

3.4 Counseling History

Descriptive statistics analysis indicated that 105 (49.5%) participants reported no history of counseling treatment *(M = 80.67, SD = 1.72)*, while 107 (50.5%) reported some

form of history of counseling treatment ($M = 86.05$, $SD = 1.71$) either during the time of the study or in the past. Further analysis of counseling history by gender concluded that those reporting no history of counseling treatment for males ($M = 78.33$, $SD = 2.33$), and females ($M = 83.43$, $SD = 2.53$), while some form of counseling history for males ($M = 84.07$, $SD = 2.59$), and females ($M = 87.96$, $SD = 2.30$).

3.5 Final Analyses

A one way analysis of variance model was employed to examine the relationships among gender, depression, and disclosure. The model showed that neither gender ($F(2, 193) = .23$, $p = .79$) nor depression ($F(3, 193) = 1.95$, $p = .122$) had significant effect upon disclosure. No interaction effect was observed. See Figure 1. Though not initially hypothesized, it was observed in the data that counseling history was significantly related to the viewed level of trustworthiness of the counselor in the therapeutic dynamic ($F(1, 192) = 13.68$, p $= .001$). The model showed that individuals without counseling treatment history ($M = 88.93$, $SD = 1.64$) expect the ideal counselor to be less trustworthy than individuals with counseling treatment history ($M = 97.19$, $SD = 1.52$).
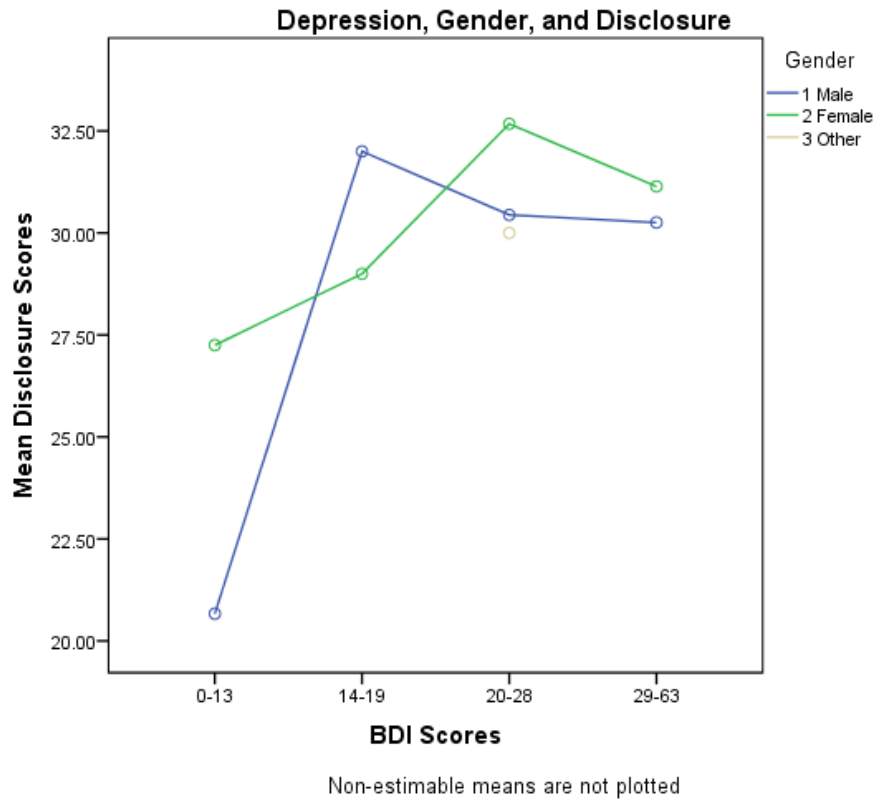
Figure 1. Distress Disclosure Index (DID) mean scores across BDI levels, by gender.

Chapter 4

Discussion

The current study sought to explore the relationship between the role of gender and depressive symptomology, and their impact on disclosure tendencies. While previous research examined the relationship between disclosure and gender (Chaudhuir, 2012; Dindia, 1992), no study has looked at the potential effects of interaction between disclosure, gender, and depression. Due to the prevalence of prominent mental health disorders in a college population (NIMH, 2012), it was necessary to research the factors that may affect this population and subsequently treatment outcomes.

Hypothesis 1: Females engage in greater levels of self-disclosure than male students. Data was consistent with the predicted hypothesis as female college students engaged in greater levels of self-disclosure than male students. Supporting the research of Dindia (1992), the endorsed data concluded a greater degree of disclosure from female participants.

Hypothesis 2: The greater the depressive symptomology the lesser degree of disclosure tendency. Data was inconsistent with the predicted hypothesis as greater depressive symptomology equated to greater disclosure. Both male and female participants with severe depression disclosed more than participants with minimal depression. Within the minimal range of depression, males ($M = 20.67$, $SD = 8.62$) disclosed less than females ($M = 27.25$, $SD = 3.6$). In the mild range of depression, males ($M = 32.00$, $SD = 2.65$) disclosed more than females ($M = 29.00$, $SD = 0.01$). In the moderate range of depression, males ($M = 30.44$, $SD = 6.50$) disclosed less than females ($M = 32.67$, $SD = 6.53$). Lastly, in the severe range of depression, males ($M = 30.25$, SD

= 6.93) disclosed less than females ($M = 31.14$, $SD = 8.23$). Such findings contradict current research (Garrison, 2012; Kahn, 2009) in that greater disclosure in therapy occurs as depression symptomology increases in severity.

Within the data there was no observed main effect between gender and depression symptomology on disclosure tendencies. There was also no interaction effect between gender, depression, and disclosure. As the first study to examine the interaction of these three factors, additional research and support is needed within the field before additional conclusions can be drawn. The importance of an interaction between gender, depression and disclosure in a therapeutic setting can serve to influence treatment planning and treatment outcomes.

Several limitations in the present study should be discussed. It is important to note the frequency of depressive symptomology endorsed by participants was predominantly in the moderate ($M = 31.04$, $SD = 2.43$) to severe ($M = 30.70$, $SD = .70$) range. As reported in the literature (NIMH, 2012; Bauer, 2013), the sample of the present study may have exacerbated the effects on disclosure as the college population endorses high rates of depression. Additional explanation for this occurrence may include the time in which data was collected, surrounding finals and the close of the semester. Further data collection may greater understand the relationship between depression, and disclosure by evaluating alternate populations throughout the lifespan.

The tendency to disclosure did not differentiate between acts of healthy and unhealthy disclosure. Research does not specify conditions for unhealthy disclosure (Derlega, 1993; Johnson, 1972) which may influence the impact that disclosure can have on treatment outcomes. Individuals meeting the diagnostic criteria for Borderline

Personality Disorder (BPD) for example, display patterns of unstable and intense relationships that may promote disclosure of information not pertaining to therapeutic growth. This tendency for intense relationships may alter the perception of developed rapport based on trust and consequently influence the rate of disclosure outlined in the present literature. Future studies should address the influence personality disorders have on disclosure tendency questioning their effect on treatment outcomes.

The environment and population of college participants may have also influenced the degree of disclosure among the data. The nature of the college setting is one in which disclosure is cultivated. Students living on campus share close quarters including personal space, bathrooms, and living accommodations. The classroom setting is often an atmosphere in which students are encouraged to offer details about themselves including background information and purpose for their enrollment. Limiting their opportunity for intimacy and boundaries this setting may have contributed to the disclosure tendency of participants. While no research has evaluated this influence, disclosure may present differently in alternative settings. The research by Foubert (1996) and Norcross (2002) addressing disclosure in the counseling relationship were centered on adults. Future studies may wish to question the impact the college setting plays on disclosure tendency.

Considerations for any inherent differences in disclosure tendencies among different racial and ethnic groups was not accounted for in the present study. As the majority of participants endorsed White/Non-Hispanic (71.7%), future research should question the influence that culture plays on disclosure tendency in the therapeutic relationship among the minority culture. Accounting for differences may better account for additional significance disclosure may have in treatment outcomes.

The disclosure tendency data in the study also included participants whom reported both a history of counseling experience and no history of counseling experience. The data was not separated based on the principle that the Distress Disclosure Index (DDI) accounted for one's overall disclosure tendency both in and outside of the therapeutic stetting. As a result, conclusions were drawn specifically to disclosure tendency important to the counseling relationship. Based on the limitation, additional research should evaluate disclosure exclusively in the counseling setting to better assist counselors in their treatment of clients prone to concealment.

In addition, it is important to note that all participant accounts of disclosure were made in retrospect and are thus unreliable. Considering the span of elapsed time since the recalled counseling experience participants may have misremembered the encounter or relationship between themselves and the counselor. Further studies may wish to evaluate participants presently in counseling to better understand disclosure. Past experience of the participants thus shaping their tendency to disclose should also be mentioned. An individual who was devalued or discouraged from acts of disclosure in the past may have been prone to greater concealment during the study. The presence of support systems outside of the counseling relationship thusly may have contributed to potential for disclosure within the counseling setting. Consideration surrounding past disclosure history should be given to current and future acts of disclosure tendency.

While preliminary data was collected from the Individualized Trust Scale (ITS) to assess the desirable characteristics of a trusted individual needed to promote disclosure, this data was not examined. In an attempt to further understand these important

characteristics in the counseling relationship facilitating disclosure, a quantifiable measure is needed in order to draw significant conclusions.

The findings of the present study also have important implications for the field of counseling. Given the extensive research surrounding the importance of the development of trust and rapport in the counseling relationship on treatment outcomes (Barber, 2000; Bordin, 1979; Fong, 1983; Foubert, 1996; Friedlander, 1970; Gatson, 1990; Gelso, 1994; Hill, 2009; Horvath, 1991; Horvath, 2002; Norcross, 2002; Strong, 1968; Thomas, 2011; Ziv-Beiman, 2013), the future training of counselors should be considered. Training in the field of counseling centers on the diagnostic understanding of mental health disorders as well as the skills to form a diagnostic conceptualization of the client and their presenting problem. Knowing the significance of rapport in the counseling relationship future training would be wise to teach the skills needed to facilitate rapport and cultivate the dynamic. In the absence of rapport enabling disclosure the counselor may need to consider making referrals as the client's needs may be beyond what the counselor is capable of delivering (Hill, 2009).

Additional understanding in regards to the role of gender, depression, and disclosure may assist in the development of rapport between the client and the counselor. Barriers limiting therapeutic growth as a result are then minimized contributing to positive treatment outcomes. It is important for clinicians to be aware of the role that depression symptomology may play on the client's ability to disclose. Depression symptoms may influence degree of disclosure thus encouragement may be needed on the counselor's behalf. As a result, this study may serve in the development for further understanding in providing the best care for those in which disclosure is limited.

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Appendix A

Demographic Information

<u>Instructions</u>: Please answer the following questions.

1) Please indicate your current age? _____

2) Please indicate your gender.
      1   Male
      2   Female
      3   Other (please explain in space)

3) Please indicate your race or ethnicity? Circle the response that corresponds to your race
or ethnicity.
      1   White/Non-Hispanic
      2   African-American/Black
      3   Hispanic/Latino/Latina
      4   Asian/Pacific Islander
      5   Native American
      6   Other (please explain in space)

4) Please indicate your current academic rank? Please circle the response that corresponds to your
academic rank.
      1   Freshman
      2   Sophomore
      3   Junior
      4   Senior
      5   Graduate student
      6   Other (please explain in space)

5) Please indicate your counseling history.
Are you currently receiving mental health counseling services (excluding career or guidance counseling)?
      1   Yes
      2   No

If you answered "yes" to the previous question, how long have you been receiving mental health counseling services? _____

Have you received mental health counseling services in the past (excluding career or guidance counseling)?
      1   Yes
      2   No

If you answered "yes" to the previous question, how long were you receiving mental health counseling services? _____

Beck's Depression Inventory

Instructions: This questionnaire consists of 21 group of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked out. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
    0 I do not feel sad.
    1 I feel sad much of the time.
    2 I am sad all the time.
    3 I am so sad and unhappy that I can't stand it.
2. Pessimism
    0 I am not discouraged about my future.
    1 I feel more discouraged about my future than I used to be.
    2 I do not expect things to work out for me.
    3 I feel my future is hopeless and will only get worse.
3. Past Failure
    0 I do not feel like a failure.
    1 I have failed more than I should have.
    2 As I look back, I see a lot of failures.
    3 I feel I am a total failure as a person.
4. Loss of Pleasure
    0 I get as much pleasure as I ever did from the things I enjoy.
    1 I don't enjoy things as much as I used to.
    2 I get very little pleasure from the things I used to enjoy.
    3 I can't get any pleasure from the things I used to enjoy.
5. Guilty Feelings
    0 I don't feel particularly guilty.
    1 I feel guilty over many things I have done or should have done.
    2 I feel quite guilty most of the time.
    3 I feel guilty all of the time.
6. Punishment Feelings
    0 I don't feel I am being punished.
    1 I feel I may be punished.
    2 I expect to be punished.
    3 I feel I am being punished.
7. Self-Dislike
    0 I feel the same about myself as ever.
    1 I have lost confidence in myself.
    2 I am disappointed in myself.

3 I dislike myself.

8. Self-Criticalness
    0 I don't criticize or blame myself more than usual.
    1 I am more critical of myself than I used to be.
    2 I criticize myself for all of my faults.
    3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
    0 I don't have any thoughts of killing myself.
    1 I have thoughts of killing myself, but I would not carry them out.
    2 I would like to kill myself.
    3 I would kill myself if I had the chance.

10. Crying
    0 I don't cry any more than usual.
    1 I cry more than I used to.
    2 I cry over every little thing.
    3 I feel like crying, but I can't.

11. Agitation
    0 I am no more restless or wound up than usual.
    1 I feel more restless or wound up than usual.
    2 I am so restless or agitated that's it's hard to stay still.
    3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest
    0 I have not lost interest in other people or activities.
    1 I am less interested in other people or things than before.
    2 I have lost most of my interest in other people or things.
    3 It's hard to get interested in anything.

13. Indecisiveness
    0 I make decisions about as well as ever.
    1 I find it more difficult to make decisions than usual.
    2 I have much greater difficulty in making decisions than I used to.
    3 I have trouble making any decisions.

14. Worthlessness
    0 I do not feel I am worthless.
    1 I don't consider myself as worthwhile and useful as I used to.
    2 I feel more worthless as compared to other people.
    3 I feel utterly worthless.

15. Loss of Energy
    0 I have as much energy as ever.
    1 I have less energy than I used to have.
    2 I don't have enough energy to do very much.
    3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern
    0 I have not experienced any change in my sleeping pattern.
    1a I sleep somewhat more than usual.
    1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.
2b I sleep a lot less than usual.
3a I sleep most of the day.
3b I wake up 1-2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any changes in my appetite.
1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.
2a My appetite is much less than before.
2b My appetite is much greater than before.
3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficult

0 I can't concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

Distress Disclosure Index

<u>Instructions</u>: Please read each of the following items carefully. Thinking about your current or most recent counseling experience, indicate the extent to which you agree or disagree with each item according to the rating scale below:

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

1. When I feel upset, I usually confide in my counselor.
   | 1 | 2 | 3 | 4 | 5 |
   | SD | D | N | A | SA |
2. I prefer not to talk to my counselor about my problems.
   | 1 | 2 | 3 | 4 | 5 |
   | SD | D | N | A | SA |
3. When something unpleasant happens to me, I often look to my counselor for someone to talk to.
   | 1 | 2 | 3 | 4 | 5 |
   | SD | D | N | A | SA |
4. I typically don't discuss with my counselor things that upset me.
   | 1 | 2 | 3 | 4 | 5 |
   | SD | D | N | A | SA |
5. When I feel depressed or sad, I tend to keep those feelings to myself.
   | 1 | 2 | 3 | 4 | 5 |
   | SD | D | N | A | SA |
6. I try to find people to talk with about my problems.
   | 1 | 2 | 3 | 4 | 5 |
   | SD | D | N | A | SA |
7. When I am in a bad mood, I talk about it with my counselor.
   | 1 | 2 | 3 | 4 | 5 |
   | SD | D | N | A | SA |
8. If I have a bad day, the last thing I want to do is talk about it.
   | 1 | 2 | 3 | 4 | 5 |
   | SD | D | N | A | SA |
9. I rarely look for people to talk with when I am having a problem.
   | 1 | 2 | 3 | 4 | 5 |
   | SD | D | N | A | SA |
10. When I'm distressed I don't tell anyone.
    | 1 | 2 | 3 | 4 | 5 |
    | SD | D | N | A | SA |

11. I usually seek out someone to talk such as my counselor to when I'm in a bad mood.
     1   2   3   4   5
     SD   D   N   A   SA
12. I am willing to tell others such as my counselor my distressing thoughts.
     1   2   3   4   5
     SD   D   N   A   SA

Appendix D

Individualized Trust Scale

<u>Part 1</u>

<u>Instructions</u>: Please read each of the following items carefully. Thinking about your current or most recent counseling experience, indicate the numbered cell best reflecting the characteristic associated with the counselor. Please answer each question.

1)	Trustworthy	__7	__6	__5	__4	__3	__2	__1	Untrustworthy
2)	Distrustful	__1	__2	__3	__4	__5	__6	__7	Trustful
3)	Confidential	__7	__6	__5	__4	__3	__2	__1	Divulging
4)	Greedy	__1	__2	__3	__4	__5	__6	__7	Generous
5)	Safe	__7	__6	__5	__4	__3	__2	__1	Dangerous
6)	Deceptive	__1	__2	__3	__4	__5	__6	__7	Candid
7)	Not Deceitful	__7	__6	__5	__4	__3	__2	__1	Deceitful
8)	Tricky	__1	__2	__3	__4	__5	__6	__7	Straightforward
9)	Respectful	__7	__6	__5	__4	__3	__2	__1	Disrespectful
10)	Inconsiderate	__1	__2	__3	__4	__5	__6	__7	Considerate
11)	Honest	__7	__6	__5	__4	__3	__2	__1	Dishonest
12)	Unreliable	__1	__2	__3	__4	__5	__6	__7	Reliable
13)	Faithful	__7	__6	__5	__4	__3	__2	__1	Unfaithful
14)	Insincere	__1	__2	__3	__4	__5	__6	__7	Sincere
15)	Careful	__7	__6	__5	__4	__3	__2	__1	Careless

Instructions: Please read each of the following items carefully. Indicate the numbered cell best reflecting the characteristic associated with an ideal counselor. Please answer each question.

1)   Trustworthy __7   __6   __5   __4   __3   __2   __1   Untrustworthy

2)   Distrustful   __1   __2   __3   __4   __5   __6   __7   Trustful

3)   Confidential __7   __6   __5   __4   __3   __2   __1   Divulging

4)   Greedy   __1   __2   __3   __4   __5   __6   __7   Generous

5)   Safe   __7   __6   __5   __4   __3   __2   __1   Dangerous

6)   Deceptive   __1   __2   __3   __4   __5   __6   __7   Candid

7)   Not Deceitful __7   __6   __5   __4   __3   __2   __1   Deceitful

8)   Tricky   __1   __2   __3   __4   __5   __6   __7   Straightforward

9)   Respectful   __7   __6   __5   __4   __3   __2   __1   Disrespectful

10) Inconsiderate __1   __2   __3   __4   __5   __6   __7   Considerate

11) Honest   __7   __6   __5   __4   __3   __2   __1   Dishonest

12) Unreliable   __1   __2   __3   __4   __5   __6   __7   Reliable

13) Faithful   __7   __6   __5   __4   __3   __2   __1   Unfaithful

14) Insincere   __1   __2   __3   __4   __5   __6   __7   Sincere

15) Careful   __7   __6   __5   __4   __3   __2   __1   Careless