# Attachment and depression: influences in self-disclosure toward the therapist

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***Abstract:*** The therapeutic relation is significant for any person who goes to the therapist. Self-disclosure is inevitable in such a relationship. Therefore, we wanted to investigate which factors are those that influence self-disclosure and how much do people actually disclose about themselves in front of a therapist. We investigated in which way the attachment style – as an internal working model – influences the self-disclosure, and also which are the differences in self-disclosure determined by depression (present/absent) and gender. Using a quasi-experimental method, we determined that secured patients tend to talk more about themselves than all the other attachment categories, and also that women speak less freely about sexuality, while men are more reserved in issues regarding their own attractiveness and relationships.
***Key words****:* self-disclosure, attachment, depression, gender, therapy

## Introduction

Bowlby (1973) saved a central place in his socio-emotional theory of development for the separation and loss experiences of the childhood, as well as for producing defense mechanisms, depression symptoms and the distortions that appear in the personality structure. He conceptualized the depressive disorders as a result of desperate situations or of helplessness which resulted from an early loss and the chronic inability of creating and maintaining affective relationships.

Bowlby (1973) underlined that some patterns of depressive disorders are the ones that are composed mainly from care-giving experiences characterized by specific patterns, as quoted by the experiences of the anxious-avoidant, resistant and disorganized attachment style. For example, the childhood experience of never obtaining a constant and safe relationship attachment, despite the repeated efforts of responding to the requests of the caregiver or unrealistic expectations (as experience of the resistant attachment) can later make the child interpret the difficulties or losses as yet another failure in influencing the environment, while wishing to maintain an affective relationship. Depression for these children will probably take place in the shape of helplessness (Simpson, Rholes, Orina, & Grinch, 2002). By repeated experiences of punishing care-giving or psychological inaccessibility, by the fact that they have verbally or behaviorally been told that they are not loved, or inappropriate (avoidant attachment experiences), the children learn to expect that the others will be hostile or negative more than welcoming and

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supportive (Bolen, 2000). From these experiences, the children can further maintain fundamental experiences of alienation and despair. Finally, Bowlby argues that the experiences of parental loss or those of trauma without auxiliary support (disorganized attachment experiences) will predispose the children into interpreting the further changes as insurmountable and themselves as incapable towards adversities. Based on that, Bowlby says that demoralizing attitudes of adolescents and children can result from schemes and self-expectancies of others that developed from earlier care-giving experiences and maintained through environmental factors.

Using environmental data, Shaw and Dallos (2005) have examined antecedents of depression that appears in childhood compared with the one from teenage years, in order to approximate the adult occurrence.

Regression analysis and group comparisons have underlined the next results: in childhood, the mother's depression, the early affective support of the baby, the emotional support of the parents and life stress variables, each being responsible for a unique variance in the hierarchy of the predictive model, have gathered a total of 19% of the variance from childhood depression (Besser & Priel, 2005).

For teenagers, the mother's depression and the early emotional support of the child gathered a total of 19% from the variance of depression. Together, the data suggests that the psycho-social factors, including the affective support of the child, are to be considered when depressive symptoms evolve both in childhood and adolescence. During teenage years, the affective support of the child and the interaction from the affective support as well as maternal depression have been factors that determined the appearance of adolescent depression (Buist, Dekovic, Meeus, & van Aken, 2004).

Extracted from the composite variables of early childhood and independently examined, the insecure attachment has significantly predicted depressive symptoms for adolescents with all the other factors controlled. The results show that early childhood experiences with disturbing value have a long term effect towards the depressive symptoms. When trying to explain the total variance of the depressive symptoms, early experiences can be more influencing than the later ones for an individual, and more important when compared with the relational support that he/she might receive later on, because early experiences play a high role in the following experiences (Egeland & Carlson, 2003).

The studies made by Hankin, Kassel, and Abela (2005) examined the relationship between the adult attachment dimensions and the affective distress symptoms (anxiety and depression). Thereby, the anxious attachment and the avoidant style have clearly predicted depressive symptoms. The cognitive risk factors, including the highly dysfunctional attitudes and low self-esteem, have underlined a relationship between the insecure attachment and possible emphasis on depression but not on anxiety. For the generating model of interpersonal stress,

when it is experimented an interpersonal relationship as addition and not as acquisition, the time stressors have emphasized the connection between insecure attachment and possible symptoms of depressive or anxiety disorder (Shaver, Schachner, & Mikulincer, 2005).

In conclusion, the results suggest that the vulnerability factors, as dysfunctional attitudes and low self-esteem, can be predictors for depression, but not for anxiety (West & George, 2002).

Other studies made in the depression and self-disclosure area have shown that after the interaction with depressive patients, there have been no major changes of attitude or hostile emotions, negative evaluations or negative estates for the partners who have been involved in short conversations, either with depressive or non-depressive individuals.

When the depressive attitude was intentional (pretended), the subjects reported avoiding feelings for the persons supposedly depressed and characterized them as being less adapted than the non-depressives (Maj, 2008).

Although the results of these studies offer consistent information about the answers of the others to the depressive patients, they don't explain why the depressives receive these kinds of negative answers. It was suggested that there are two factors which determine the avoiding behaviors: the first is the depressive affect, which refers to non-verbally displaying sad or flat emotions (as part of the depressive symptoms) and the second is the depressive self-disclosure, as a verbal component, which consists in the affirmation that the depressed patient is making about himself. According to Beck, the verbalization refers to negative cognitions about the self, the world and contains specific themes as self-blaming, self-discrediting, negativity, despair and helplessness.

The information disclosed by the depressed don't seem to differ much more than the ones made by the non-depressed, except regarding its intimacy, more exactly, when the conversation topic is negative, the depressed tend to resonate more and disclose themselves. Actually, in general, the tone of the information they are disclosing is negative, either it is the content, the self-affirmations or the negative emotions (Meleshko, 1994).

The therapists benefit knowing the things that their clients choose to disclose, as well as the ones that they prefer to keep for themselves. Anyway, the researches made on self-disclosure, including the factors that influence this behavior are just a few. Some of the first researches made by Jourard (as cited in Boncu, 2005) included the therapist as a potential receiver of the self-disclosure, although the subjects from his studies weren't clients but students who had to imagine if they would disclose themselves to a therapist or not. In a study about „What patients don't tell their therapists", Weiner and Shuman (as cited in Farber, 2003, p. 593) found that 42% of their experimental group hid information from their therapist regarding one of the further categories: violent thinking, violent

facts, sexual thinking, sexual facts, financial problems, possible illegalities, drugs or other medication and other subjects.

Some of Hill's and colleagues' studies (as cited in Farber, 2003) found that subjects will immediately hide their reactions towards negative experiences (feeling scared, confused, misunderstood or blocked) more often than the positive ones (feeling understood, supported, or optimistic). The clients who feel negative attitudes don't want their therapists to know about it. These results are congruent with the one made by Rennie (as cited in Farber, 2003), who discovered that clients use two simultaneous levels in therapy: one that activates cooperation and pleasure and one that activates resentments and doubt. The clients from these studies admitted the fact that they had been refractive in expressing their negative feelings, most of them expressing that they weren't capable of challenging their therapist, that it wouldn't have been right to criticize when that treatment was meant to help them, or that this kind of behavior would jeopardize a very good therapeutic relationship. The cumulated research indicate that most of the clients use the idea: "If you are not capable of saying something nice, don't say anything at all." (Weissel & King, 2007).

Almost two thirds of the patients in long term therapy were aware that they hadn't said certain things about themselves, half of them admitted that they had kept secrets, most of them referring to the difficulty in relationships, sexual problems or failure feelings (Stricker, 2003). It is very important to know that the therapists from these studies rarely knew what clients hid in therapy. So it seems that almost half of the patients had secrets towards the therapists, some of them referring to the therapy process and some to long term problems.

Farber and Hall (2002) discovered that, associating a wide range of subjects from medium to highly intimate, clients believe they disclose themselves in a medium way (3.2 on a 5 point scale). Most of the individuals had one or two topics for which they came to therapy and about which they talked regularly. In fact, discovering that the subjects talked about a wide range of topics might be a sign of resistance and also a sign that they didn't approach the topic for which they came to therapy.

Generally, patients disclosed themselves on themes of personal value, dysphoria and the nature of relationship with others; told a little different, patients talked mostly about the disappointment and frustration they felt for the people near them. More specific, the items with the highest value at self-disclosure were: "aspects of my personal value that I disapprove, worry or tend to feel as a handicap", "parents characteristics that I dislike", "feelings of despair, depression or discouragement", "my anger feelings toward my parents" and "my anger feelings towards my partner" (Hall & Farber, 2001).

What do they talk about less? The research in this area has suggested that the most difficult topics to disclose are sexual and body experiences. More specific, items as: "My sexual fantasies towards the therapist", "My interest towards

pornography", "My hygiene habits" and "My experience and my feelings towards masturbation", had the lowest score on self-disclosure. To these, can be added other items connected with sexuality, including the ones referring to virginity or sexual fantasies (Hall & Farber, 2001). A surprise is the one of finances, considered to be a taboo subject and which seemed to be very easy to discuss in therapy (Farber & Hall, 2002). We can add subjects as violence or abuse towards someone which are as well very difficult to disclose in therapy.

The fact that the clients did not reveal themselves entirely in therapy has been asserted to various circumstances. Most of this phenomenon has been addressed to conscious inhibition, because of fear or shame of disclosing certain thoughts or feelings. Likewise, the clients hid things because of their belief that they could influence the therapist, for example by not telling them that they were not satisfied with the results of therapy. Actually, there were more factors that inhibit self-disclosure, one of these factors being the fact that those things weren't thought to be important during the therapy (Derlega, Winstead, Mathews, & Braitman, 2008).

## Methodology

The present study wanted to investigate the manner in which these patients disclosed themselves towards their therapists, how much they disclosed and which were the topics that created the most difficulties in this area.

We examined the attachment pattern that the patients activated when they first went to the therapist and if this pattern influenced self-disclosure.

Another variable taken into consideration was the depression and the way in which its presence or absence interfered in self-disclosure.

### Hypotheses:

**1.** There is an interaction effect of the variables "attachment style" and "presence/absence of depression" concerning the level of self-disclosure of the patient towards his/her therapist.

**2.** There is an interaction effect of the gender and presence or absence of depression regarding the level of self-disclosure of the patient in his/her relationship with the therapist.

**3.** There are significant differences between the preferred topics of self-disclosure as they are influenced by the attachment style, depression or gender.

### Experimental group

The subjects investigated in our research were 112 patients from the urban area, 35.7% men and 64.3% women. The average age was approximately 40 years, 32% of the patients being married, 28 % unmarried, and 36% separated. A small percentage made up the widowers at 3.6%.

All the patients were categorized in an experimental group, according to their attachment style or depression level, based on the scores they obtained after answering the questionnaires. Patients were either from The Clinical Psychiatric Hospital “Socola”, who had benefited from therapy, during their hospitalization there, and also patients who had been to a therapist outside the hospital. Because it is very difficult to gain access to patients who are involved in therapy and especially to the ones that are hospitalized, it was impossible to control variables such as therapist gender or psychiatric diagnosis. Patients were asked to think about a therapist that represented an important figure to them, either the current one or a person from their past experiences.

**Instruments**

In evaluating the *attachment style* we utilized a questionnaire made by Eva Pollack and her colleagues for the Bielefeld University in Germany. This questionnaire was created in order to evaluate the attachment style of the patient toward his/her therapist (Pollack, Wiegand-Grefe, & Hoger, 2008).

In this questionnaire, the patients who went to therapy were asked their opinions regarding the therapeutic relationship. This instrument is based on the premises that the patients enter a relationship in a state of anxiety and distress, so that their attachment system is activated. This way, their expectations regarding the therapeutic relationship and behavioral tendencies are influenced by the internal attachment model.

The questionnaire had 33 items and the subjects were divided into 5 groups, as follows: avoidant-withdrawing, partially secure, secure, ambivalent-clinging and ambivalent-withdrawing, based on three scales: the fear of rejection, the readiness for self-disclosure and the conscious need for care. For this instrument, which has been translated from English, we obtained an internal consistency coefficient alpha= 0,756.

For the evaluation of *the depression level*, we utilized the Beck Depression Inventory, which contains 21 items, characterizing the depressive symptoms on a 4 point Likert scale. The scores lower than 17 were characterized as non-depressive while the higher scores characterized different intensities of depression. During the research, we did not study the intensity of depression but the division of the subjects in depressed and non-depressed.

For the evaluation of *self-disclosure* we used two instruments, as follows:

*Self-evaluation of disclosure*

This instrument desires to evaluate how much the people disclose in general towards their therapist, a high score characterizes a high level of self-disclosure, while a low score, a low level of self-disclosure.

The self-disclosure questionnaire was created based on five dimensions: intentionality, quantity, positivism, intimacy and honesty. The instrument that we created has 31 items and we obtained an internal consistency alpha= 0,873.

*Disclosure toward the therapist*

In order to create this instrument, we started from the instrument made by Farber (2002) which regards to the self-disclosure toward the therapist (Disclosure to Therapist Inventory- Revised). This instrument was translated, but we didn't keep all its questions, only the ones that a series of experts (Master students for Clinical Psychology and Psychotherapy) had considered to be causing difficulties in self-disclosure. The internal consistency was alpha= 0,793.

**Results and interpretation**

**1**. The first hypothesis was actually tested in three phases:

1.1 the effect of the attachment style over the level of self-disclosure;

1.2 the effect of the depression over the level of self-disclosure;

1.3 the interaction effect of the attachment style and depression over the level of self-disclosure.

The previous hypotheses were tested by statistical methods of means comparisons. For all the further results we checked the normality of the data, by Levene's test of Variance, all of them obtaining a significant p-level.

**1.1 The effect of the attachment style over the level of self-disclosure.**

To test this effect we used the One-way Anova. From the results obtained ($F(4,107) = 26.06$; $p \leq 0.001$), we confirmed that there is a difference between the attachment styles, regarding the self-disclosure level.

Table 1 *Differences between Attachment styles, concerning the level of self-disclosure*

| **Attachment style** | | **Average difference** | **p** |
|---|---|---|---|
| **A** | **B** | **A-B** | |
| Avoidant-withdrawing | Partially secure | -8.87 | 0.293 |
| | Secure | -43.66 | 0.000* |
| | Ambivalent-clinging | -10.25 | 0.351 |
| | Ambivalent-withdrawing | 7.00 | 0.937 |
| Partially secure | Secure | -34.79 | 0.000* |
| | Ambivalent-clinging | -1.37 | 1.000 |
| | Ambivalent-withdrawing | 15.87 | 0.001* |
| Secure | Ambivalent-clinging | 33.41 | 0.000* |
| | Ambivalent-withdrawing | 50.66 | 0.000* |
| Ambivalent-clinging | Ambivalent-withdrawing | 17.25 | 0.003** |

Note: * = $p \leq 0.001$, **= $p \leq 0.05$

According to the Bonferonni test, the differences between the averages are significant, the secured subjects disclosing themselves more than all the other categories. As well, the ambivalent-withdrawing has a lower level of disclosure compared to the ambivalent-clinging.

**1.2. The effect of the depression over the level of self-disclosure.**

Using the T-test for Independent values we found that there were significant differences ($t(110) = 0.022 \leq 0.05$) regarding the level of self-disclosure for the depressed patients (M1=110,500) who disclosed themselves less than the non-depressed (M2=119.357).

**1.3. The interaction effect of the variables attachment style and level of depression regarding the level of self-disclosure.**

The results that we obtained show that there is no interaction effect between the two independent variables towards the level of self-disclosure of the patient. The only significant result is the influence the attachment style has upon the level of self-disclosure.

Table 2. *Attachment styles x Depression Analysis of Variance for the level of Self-disclosure*

| Independent variables | Df | F | P |
|---|---|---|---|
| (A) Attachment style | 4 | 22.586 | 0.001* |
| (B) Depression | 1 | 1.949 | 0.166 |
| A x B (interaction) | 4 | 1.203 | 0.303 |

Note: * = $p \leq 0.001$

The results can be in this case insignificant, because there are a small number of subjects for certain experimental groups, which might make the statistic analysis a little difficult. In the general population, there is not a homogeneous distribution, and the fact that we didn’t have a representative sample, but an experimental group, is one of the limits this research has.

This is the reason for which we went further with the data investigation, by splitting the group according to each attachment style and look for any differences in each group between the depressed and non-depressed regarding the level of self-disclosure.

Table 3. *Differences between the depressed and non-depressed concerning the level of self-disclosure for each attachment style*

| **Attachment style** | **T** | **p** | **M1 (non-depressed ) – M2 (depressed)** |
|---|---|---|---|
| Avoidant-withdrawing | 3.518 | 0.004* | 10.66 |
| Partially secure | -1.440 | 0.161 | -5.85 |
| Secure | 4.747 | 0.001* | 13.00 |
| Ambivalent-clinging | | Impossible comparison | |
| Ambivalent-withdrawing | 0.387 | 0.702 | 2.8 |

= $p \leq 0.01$

As it can be noticed from the table, there aren't differences except in the case of the secured patients and the avoidant-withdrawing, in both cases, the non-depressed disclosed themselves more than the depressed.
Further on, we split the group after the depression level. We will display on Table 4 the cumulated data for both the depressed and non-depressed, showing just the significant differences.

Table 4. *Differences between attachment styles concerning the level of self-disclosure for the non-depressed and the depressed (only significant data)*

| **Depression** | **Attachment style** | | **Difference between averages** | **p** |
|---|---|---|---|---|
| Non-depressed | Avoidant-withdrawing | Secure | -42.66 | 0.000* |
| | Partially secure | Secure | -39.85 | 0.000* |
| | Secure | Ambivalent-clinging | 53.00 | 0.000* |
| Depressed | Avoidant-withdrawing | Secure | -40.33 | 0.000* |
| | | Ambivalent-clinging | -15.58 | 0.013** |
| | Partially secure | Ambivalent-withdrawing | 21.800 | 0.016** |
| | | Ambivalent-clinging | 24.75 | 0.005** |
| | Secure | Ambivalent-withdrawing | 42.80 | 0.000* |
| | Ambivalent-clinging | Ambivalent-withdrawing | 18.05 | 0.000* |

* = $p < 0.001$, **= $p < 0.01$

Thereby, for the non-depressed patients, the data confirms that the patients with a secured attachment style self-disclosed more than the avoidant-withdrawing, the partially secured and the ambivalent-withdrawing patients.

For the depressed patients, the secured ones self-disclosed more than the avoidant-withdrawing style, ambivalent-clinging and the ambivalent-withdrawing styles. In the same group, the ambivalent-clinging patients disclosed more than the ambivalent-withdrawing and avoidant-withdrawing. Likewise, the partially secured patients self-disclosed more than the ambivalent-withdrawing group.

**The combined effect of the variables gender and depression towards the level of self-disclosure.**

For the research of this hypothesis we used the Anova Univariate procedure.

Table 5.

*Gender x Depression Analysis of Variance for the level of Self-disclosure*

| Independent variables | df | F | p |
|---|---|---|---|
| (A) Gender | 1 | 2.306 | 0.132 |
| (B) Depression | 1 | 16.422 | 0.000* |
| A x B (interaction) | 1 | 24.481 | 0.000* |

* = $p \leq 0.001$

Although there is no primary effect of the variable gender upon the level of self-disclosure, there is a primary effect of the variable depression upon the level of self-disclosure and a combined effect of the two variables upon the degree of self-disclosure of the patients.The averages and standard deviations for the four experimental groups are synthesized in the table below:

Table 6.

| Independent variables | | Depression | |
|---|---|---|---|
| | | Non-depressed | Depressed |
| Gender | Men | 136.25<br>SD=20.80 | 103.33<br>SD=14.23 |
| | Women | 112.60<br>SD=20.13 | 115.87<br>SD=17.08 |

Thereby, we obtained significant differences for the non-depressed patients, men disclosing themselves more than women in front of the therapist.

For the depressed however, the things were different, the depressed women disclosing themselves more than the depressed men, as it can be seen from the next table:

Table 7. *Differences between men and women concerning the level of self-disclosure for each level of the variable depression:*

| Depression | t | p | M1(men)-M2(women) |
|---|---|---|---|
| Non-depressed | 3.934 | 0.000* | 23.65 |
| Depressed | -2.915 | 0.005** | -12.54 |

*= p≤ 0.001, ** =p≤ 0.01

Likewise, the men who were non-depressed disclosed themselves more than the depressed ones, while for the women there was no difference in self-disclosure, either they were depressed or not.

Table 8. *Differences between non-depressed and depressed concerning the level of self-disclosure for both men and women:*

| Gender | t | p | M1(non-depressed)-M2(depressed) |
|---|---|---|---|
| Men | 5.953 | 0,000* | 32.916 |
| Women | -0.733 | 0.466 | -3.275 |

* = p≤ 0.001

These results are inconsistent with the previous researches and it would have been interesting to find out whether the diagnosis of the non-depressed could influence the quantity of self-disclosure information, especially for the male group. It has been noticed in clinical work that men usually are more involved in therapy than women and this might be a reason why the scores in self-disclosure were so much higher than the ones in the female group, but this topic could become the subject of new research.

**3. Differences in self-disclosure**

According to our research, the items with fewer problems in self-disclosure are:

| Item no. | Item | Average | Standard deviation |
|---|---|---|---|
| Item 16 | „About the sufferings that I have to endure now (in my family/at my work)” | 2.321 | 0.761 |
| Item 13 | „The way I was affected by my traumas.” | 2.321 | 0.932 |
| Item 5 | „The feelings that I cannot control or express.” | 2.321 | 0.932 |

On the other hand, the items with the lowest scores for self-disclosure are:

| Item no. | Item | Average | Standard deviation |
|---|---|---|---|
| Item 1 | „My opinions towards the sexual morality” | 1.285 | 0.840 |
| Item 6 | „Aspects of my present sexual life.” | 1.464 | 0.909 |
| Item 7 | „Whether I feel attractive or not for the opposite sex.” | 1.464 | 0.985 |
| Item 14 | „My previous relationships or my extramarital affairs.” | 1.357 | 0.858 |

We’ve synthesized the differences between all the items that had low levels in self-disclosure and high scores in that topic according to the attachment style, the absence/presence of depression and gender in the next table, as follows:

Table 9. *Differences in self-disclosure topics*

| | | **Item numbers** | |
|---|---|---|---|
| | | **High level of self-disclosure** | **Low-level of self-disclosure** |
| **Attachment style** | **Avoiding-withdrawing** | Items 16, 4, 5, 13 (M>2.5) | Items 7, 1, 8 (M<1.5) |
| | **Partially secure** | Items 13, 16, 2 (M>2.25) | Items 6, 1, 7 (M<1.25) |
| | **Secure** | Items 17, 20, 13, 2 (M>2.33) | Items 6, 9, 11, 12, 14, 15, 19 (M=1.00) |
| | **Ambivalent clinging** | Items 5, 2, 4 (M>2.75) | Items 19, 6, 14 (M<1.75) |
| | **Ambivalent-withdrawing** | Item 3, 18, 17 (M>2.14) | Items 14, 12, 1 (M<0.85) |
| **Depression** | **Depressive** | Item 3, 5, 16 (M >2.2) | Items 1, 2, 14 (M<1.15) |
| | **Non-depressive** | Items 2, 13, 16 (M>2.3) | Items 6, 12, 11 (M< 1.5) |
| **Gender** | **Feminine** | Items 13, 5, 2 (M >2.4) | Items 12, 1, 14 (M<1.4) |
| | **Masculine** | Items 16, 10, 5 (M>2.1) | Items 7, 6, 1 (M≤1.1) |

Note: The items as presented in the Self-disclosure Inventory (Annex) are listed in the order of their highest/lowest value.

## Conclusions

There is a main effect of the variable attachment style of the client for the therapist over the client's level of self-disclosure towards him/her – effect that is caused by the differences between the five attachment styles. Therefore, the secured patients disclose themselves more than all the other styles, followed by the partially secured, while the ambivalent-withdrawing style is the less self-disclosing style.

Also, there is a main effect of the variable depression (presence/absence) towards the level of self-disclosure in front of a therapist; this means that the depressed disclose themselves less than the non-depressed. Probably the depression symptoms (like the lack of energy) make the patients feel incapable of healing with their own resources and therefore they find no reason to disclose themselves, not even to a therapist. Usually, especially in Psychiatric Hospitals, patients have been brought by relatives and therefore their involvement in therapy and as well, the readiness for self-disclosure might be affected, because of their expectations that may not involve the idea of needing to do something on their own in order to be cured.

There is no interaction effect for the variables, attachment style and depression towards the level of self-disclosure in front of the therapist, the combined effect of the two variables is partially saying that the avoidant-withdrawing patients , as well as the secured ones, both of them non-depressed, have a higher level of self-disclosure than the depressed ones from the equivalent categories. For the non-depressive participants, the ones with the highest level of self-disclosure are the secured ones, and that is also available for the depressed.

There is an interaction effect of the variables gender and depression for the level of self-disclosure; the non-depressive men disclosed themselves more than the women, while for the depressed, women tended to disclose more than the men. The depressed men disclosed themselves less than the non-depressed, but women tended to disclose equally, whether they were depressed or not.

This result is in contradiction with Jourard's early work (1971) which indicates that, in general, women disclose more than men. In contrast, one study made by Weiner & Shuman(1984, as cited in Farber, 2003), that focused specifically on the therapeutic situation, found that women disclose less than men and that women most often withhold discussion of sexual material whereas men are more reluctant to discuss issues related to violence.

As well, in our study there are differences in self-disclosure regarding the topics approached in therapy: patients usually accepted to talk more about their problems, about their traumas or about the feelings that they couldn't control or express, but disclosed less on matters such as sexual life and morality, the attractiveness for the opposite sex and their possible extramarital affairs.

In setting these conclusions, we started from a theoretical model which was adapted and later confirmed through statistical processing. The adaptation to the

socio-cultural context can be at times difficult and the external theoretical models might not fold on the studied population. An analysis of the cultural, situational and, why not, therapeutic factors, that influence the level of self-disclosure is necessary. The subjects that the patients approach in therapy are however up-to-date.

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**Appendix**

Self-disclosure Inventory

*Please write a score for each of the following items according to the next significations, while thinking about the current or last therapeutic relation:*

**0: I lied or presented myself in a false manner so that my therapist might have a better opinion about me.**

**1: I hadn't told my therapist anything about this issue.**

**2: I talked in general with my therapist about this subject. My therapist has a general idea about this problem.**

**3: I talked openly with my therapist about this problem. My therapist knows all the aspects concerning this and he/she could give details about this issue.**

1) My opinions towards the sexual morality – the way I think we should behave in a sexual relationship.
2) About my flaws and what keeps me from evolving the way I would desire.
3) How much/ how little I earn; my financial problems.
4) Aspects of my own personality that I consider a handicap.
5) The feelings that I cannot control or express.
6) Aspects of my present sexual life – including problems, level of sexual satisfaction, difficulties.
7) Whether I feel attractive or not for the opposite sex; my problems in receiving positive attention from a partner.
8) Things in the present or in the past that I feel guilty or ashamed about.
9) Moments when I have been so angry, I became aggressive towards the dear ones.
10) Things that make me feel ashamed about myself, that decrease my self-esteem or my respect.
11) What I don't like about my appearance and how I would have wanted to look different.
12) My thoughts about how adequately I behave sexually speaking.
13) The way I was affected by my traumas.
14) My previous relationships or my extramarital affairs.
15) The abuses I suffered during childhood.
16) About the sufferings I have to endure now (in my family/at work).
17) The vices I have (alcohol, smoking, drugs).
18) Thoughts that I have which are completely against my familial, moral or social rules.
19) About the way I felt while doing something illegal.
20) About my previous failures, either relational or professional