Running Head: SELF SILENCING AND SOCIAL SUPPORT

Self-Silencing and Depression in Women: Examining the Role of Social Support as a Moderator

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ABSTRACT

In almost all populations there is a significant sex difference in the rate of depression, with women being twice as likely to be depressed as compared to men (Bebbington, 1996; Kuehner, 2003). Numerous theories have been proposed in an attempt to explain this difference, with one such theory being Jack's (1991) Silencing the Self Theory which poses that, in adherence to the traditional female role, many women self-silence in an attempt to maintain their intimate relationships, which increases the risk of depression (Jack 1991). However, the relationship between self-silencing and depression is not necessarily direct thus suggesting that another variable, such as social support, may be moderating the relationship. In order to investigate the role of social support as a moderating variable the present study was designed with two parts. The first adopted a quantitative paradigm to investigate the amount and satisfaction with the emotional and practical support received from two sources (partner and others). The results found that depression bore a positive relationship to self-silencing and a negative relationship to social support but did not corroborate the expectation that social support would act as a moderator between self-silencing and depression. The second part of the study used qualitative methodology and involved small focus groups of high and low self-silencing women. Thematic analysis was used to analyse the narratives and the current study found that the women in the low self-silencing group self-silenced to preserve harmony in the relationship while the women in the high self-silencing group did so when they felt that others' needs were more pressing than their own. In conclusion, social support did not act as a moderator between self-silencing and depression in women. As well, high self-silencing women received less social support and were less satisfied with the support they received from their partner and others, relied on more avenues of social support simultaneously, and self-silenced to preserve harmony in their relationships.

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~ Jessica

Dedication

I would like to dedicate this thesis to my sister, Annie Johnson. You inspire me to work harder, to laugh louder, to care deeper and to always keep going.

TABLE OF CONTENTS

LIST OF APPENDICES

LIST OF TABLES

LIST OF FIGURES

Depression is a serious mental illness that affects over 1,210,000 Canadians a year (Kirby & Keon, 2004). Depression is much more than just "feeling blue"; it encompasses a range of debilitating symptoms from continuous depressed mood, loss of interest in or pleasure in activities, psychomotor agitation or retardation to thoughts of suicide. The typical age of onset is in the mid to late twenties; however, the disorder can manifest at any age (Goodwin, Jacobi, Bittner, & Wittchen, 2006).

Adolescence is a critical time in the development of depression during which the sex differences in the prevalence rates of depression emerge (Nolen-Hoeksema, & Girgus, 1994). Moreover, research has found adolescent depression to be associated with a number of serious social and health consequences. Glied and Pine (2002) found that depressed adolescents reported more alcohol and drug use, were more likely to smoke, and had higher levels of bingeing behaviour. As well, these depressed adolescents had increased difficulties in school and were reported to have missed more days of school then their non-depressed peers. This study also found that depressed adolescents reported substantially more suicidal ideation compared to their non-depressed peers. Additionally, studies have found that difficulties such as these during adolescence can lead to continuing psychiatric disorders during adulthood (Rao et al., 1995; Weiner & DelGaudio, 1976).

On the other end of the developmental spectrum, researchers have also begun to focus on differences between depression in elderly adults and their young and middle-aged counterparts. In particular, depression in the elderly is frequently unrecognized or misdiagnosed because of a misconception that depression is a normal result of aging and that "true" depression is thought to be rare among seniors. In reality, international studies (see Djernes, 2006) find depression to be common in the elderly with the prevalence of major depression ranging from 1% to 9.4% in

community dwelling seniors and from 14% to 42% in seniors residing in nursing homes. The recognition of depression in the elderly is often confounded by associated physical disorders such as heart disease, cancer and Alzheimer's, causing depressive symptomology to be overlooked as merely side effects of the physical disorder (Cooke & Tucker, 2001). Likewise, many of the normal changes that come with aging mirror symptoms of depression, such as reduced sleep or fatigue, which can make the detection of depression difficult (Small, 1991). However, the consequences of ignoring depression in individuals of any age can be detrimental. Not only does depression interrupt family life and employment, and increase costs to the medical system, it is also associated with a high risk of suicide (Knapp, 2003; Oquendo, Ellis, Greenwald, Malone, Weissman, & Mann, 2001). Thus, it has become important to explore and understand the various causal factors and consequences of depression.

The term "depression" is often used in an open-ended way to encompass a range of mood disorders including major depressive disorder, dysthymia, and subclinical depression. According to the criteria set out by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000), major depression is "characterized by one or more major depressive episodes without a history of manic, mixed or hypomanic episodes" (p. 369). In addition, these episodes must not be the result of a medical condition, not be substance induced or not be better accounted for by another disorder. Subsequently, a major depressive episode is characterized by either a persistent depressed mood described as feeling sad, hopeless or having no feelings, or a loss of interest and pleasure in most activities. These symptoms must continue for at least two weeks and be accompanied by at least four other associated symptoms including weight loss or gain and changes in appetite, problems sleeping, psychomotor agitation, fatigue, feelings of guilt and

worthlessness, poor concentration, and recurrent thoughts of death or suicide. These depressive episodes cause significant distress and often critically impair functioning, although for some, what appears to be normal functioning can be maintained through substantial personal effort. The depressive episode itself may last for months or longer at which time the symptoms may go into partial or full remission. Moreover, the occurrence of each episode increases the risk of suffering subsequent episodes (American Psychiatric Association, 2000).

A mood disorder similar to major depression is dysthymic disorder or dysthymia. In comparison to major depression, which is characterised by specific depressive episodes, dysthymia features prolonged feelings of moderate depression for more days than not for a period of at least two years (Keller et al., 1995). In addition, dysthymic individuals should report at least two of the following symptoms: disinterest in food or over eating, insomnia, loss of energy, low self-esteem, hopelessness and difficulty concentrating or making decisions. In order to receive a diagnosis of dysthymia there must be an absence of any major depressive episodes during the first two years, as well as the absence of any manic or hypomanic episodes. However, there is a significant risk that individuals with dysthymia will eventually suffer a major depressive episode at which point a diagnosis of "double depression" may be given (American Psychiatric Association, 2000).

Research has also focused on subclinical depression or sub-threshold depression. In essence, these terms are used to classify individuals who have some significant depressive affect and other symptoms of depression but do not meet enough criteria to warrant a full diagnosis of major depression or dysthymia (Klein, Shankman, & McFarland, 2006). The current DSM-IV-TR discusses the potential for a classification of disorder entitled minor depressive disorder, which would require individuals only meet criteria of two, but less than five symptoms in

addition to depressed mood or loss of interest in activities. However, there is still insufficient research on the topic to enable minor depressive disorder to be included in the tome (American Psychiatric Association, 2000). Nonetheless, the level of functional impairment associated with sub-clinical depression can be quite significant. As well, the level of symptom severity can range from mild to moderate and can include a range of cognitive and mood related dimensions (Rapaport et al., 2002). Furthermore, research has also found that current subclinical depressive symptoms are associated with increased risk of subsequent first-onset of major depressive disorder (Horwath, Johnson, Klerman, & Weissman, 1992). Thus, sub-clinical depression appears to warrant further attention and research.

A variety of scales and measures have been developed to aid in the diagnosis of depression, the assessment of the severity of symptoms and the monitoring of change in symptom severity over time. Among some of the most prominent of these measures are the Structured Clinical Interview for DSM-IV (SCID; First, Spitzer, Gibbon, & Williams, 1996), the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1994), the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) and the Hamilton Depression Rating Scale (HAM-D; Hamilton, 1960).

The SCID is a structured interviewing tool designed to assist practitioners in making reliable and standardized diagnoses of mental disorders. It covers the most commonly seen DSM-IV disorders including major depression and dysthymia. The SCID reports excellent reliability and strong validity that is tied to the rigour of the DSM-IV (as cited in Nezu, Ronan, Meadows, & McClure, 2000). A recent work by Zanarini and Frankenburg (2001) found the SCID to have excellent inter-rater reliability with high kappas ranging from .69 to 1.0. Specifically, the inter-rater reliability for major depression and dysthymia was in the very high

range, .90 and .91 respectively. The SCID has also been found to be extremely valid and is considered by many to be the standard for structured interviews (Basco et al., 2000; Fenning, Craig, Lavelle, Kovasznay, & Bromet, 1994). As it stands, the SCID remains prevalent for use in both clinical and research settings.

The Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1994) is a self-report inventory of pathology designed to aid clinicians in the evaluation of psychological symptoms. The scale addressed the symptomology representative of nine dimensions of disorder including depression. The SCL-90-R has good psychometric properties and is useful in aiding practitioners in making a diagnosis of depression or identifying cases of subclinical depression (as cited in Nezu et al., 2000). Recently, concern has arisen over the dimensionality of the SCL-90-R. It has been argued that the scale would be best viewed as a measure of global pathology and not interpreted by the subscales. Some evidence from factor analysis has supported this idea. For example, Rauter, Leonard, and Swett (1996) found, in their analysis, the first factor to emerge was very large and accounted for over 40% of the variance followed by a number of minor factor clusters that accounted for significantly less variance. However, studies that examine the discriminant validity of the SCL-90-R find it continues to demonstrate good validity, in particular in discriminating among anxious, depressive and other disorders (Rief & Fichter, 1992). Thus, it would seem that, when used in a cautious and professional manner, the SCL-90-R remains useful in aiding in the diagnosis of depression.

Alongside the aforementioned tools are the BDI-II and the HAM-D that are designed to measure the severity of depressive symptoms in adults. The BDI-II is a 21-item self-report measure that covers a range of symptoms outlined in the DSM-IV. It is applicable for use with a variety of mood disorders including major depression and bipolar disorder. The HAM-D is a 21-

item scale, with 17 core items used for calculating severity, originally designed to be incorporated into the clinical interview. It is particularly useful in tracking changes in symptom severity over the treatment period. Both instruments have good reliability and validity and are used extensively in the research literature (as cited in Nezu et al., 2000). Even though the two scales are highly correlated, comparative factor analysis reveals that each scale focuses on different dimensions of depression. The BDI-II appears to focus more on cognitive and affective dimensions of depression, which would be expected giving the cognitive nature of Beck's depression theories on which the scale is based. In comparison, the HAM-D is more concentrated around behavioural and somatic symptoms of depression. (Brown, Schulberg, & Madonia, 1995). Choice of which scale to use often comes down to the preference of the practitioner. However, it could be argued the HAM-D, with its focus on somatic symptoms, is more appropriate for use with women as they often report somatic symptoms and atypical features (including changes in sleeping and weight) of depression (Matza, Revicki, Davidson, & Stewart, 2003; Silverstein, 1999).

SEX DIFFERENCES IN DEPRSSION

Epidemiological research has found that, in general, women have significantly higher prevalence rates of depression, as compared to men (Bebbington, 1996; Kuehner, 2003). In Canada, a recent wide scale survey of the population supported these findings. The Canadian Community Health Survey: Mental Health and Well-Being (CCHS 1.2) found women have significantly higher rates of depression as compared to men, with the annual prevalence rate of approximately 5% for women and 2.9% for men. (Patten et al., 2006)

A smaller study of Ontario residents found similar differences in the one-year prevalence rates between women (5.4%) and men (2.8%) (Offord et al., 1996). Likewise, an earlier study by

Bland, Orn, and Newman (1988) found the lifetime prevalence rate of depressive disorders in an Alberta sample to be 11.4% for women and 5.9% for men.

Similar discrepancies between female and male prevalence rates of depression are found in most Western countries. A national study in the United States found the lifetime prevalence rate for women to be 12.6%, which was significantly higher than the 6.3% prevalence rate for men (Riolo, Nguyen, Greden, & King, 2005). A study of young American adults by Jonas, Brody, Roper, and Narrow (2003) found that, once again, the rates of major depression were almost twice as high in women (11.2%) as in men (6.0%). Moreover, results of the European Commissions' Outcome of Depression International Network (ODIN) study, designed to compare depression in rural and urban settings in five European countries, found women to have higher depression rates as compared to men (10.05% vs. 6.61%) for the prevalence rates of all the sites combined (Ayuso-Mateos et al., 2001). This discrepancy was particularly evident in urban communities, as in England where the rate was 24% of women compared to 10.3% of men and in Ireland where the rate was 20.0% of women and 7.3% of men.

Interestingly, some research has found that this disparity in female and male depression prevalence does not always maintain the approximate 2:1 ratio within certain special populations. Even within the ODIN study, researchers found that, while most countries had significant discrepancies in prevalence rates, women and men in urban Spain had almost equal rates of depression, 2.6% and 2.5% respectively (Ayuso-Mateos et al., 2001). In her definitive work on sex differences in depression Nolen-Hoeksema (1990) reports a number of special populations that appear to lack a different prevalence rate by sex. Among these groups were the Old Order Amish, college students, widowed adults and elderly adults. However, newer studies have demonstrated, with some of these populations, that there is a difference in the rate of

depression between women and men as is seen in the general population (Dion & Giordano, 1990; Sonnenberg, Beekman, Deeg, & van Tilburg, 2000; Tomoda, Mori, Kimura, Takahashi, & Kitamura, 2000).

Since the late 1980's there has been a large increase in the research focusing on the elderly and it appears the rates of depression in senior populations is not equal among women and men as was once thought. A study by Sonnenberg and colleagues (2000) found that, not only did depression increase with age for seniors aged 60 to 85, but women had significantly higher rates of depression at every age interval after 60. Depression rates for women ranged from 15.5% to 24.7% compared to 7.3% to 13.8% in men. Moreover, a large review of the literature since 1993 concluded that in most populations of the elderly, women have higher rates of depressive disorders (Djernes, 2006).

Similarly, differences in the rate of depression among female and male university students were at one time thought to be nonexistent (Hammen, & Padesky, 1977; Nolen-Hoeksema, 1990). However, more recent studies of the sex differences in rates of depression among college students have found conflicting results. Some studies continued to find equal prevalence rates for depression in female and male students. For example, Grant et al. (2002) found that undergraduate women and men had equal rates of depressive mood and male students actually had a higher rate of depressive disorder. In contrast, a number of other studies found female students to have a higher prevalence of depression. Dion and Giordano (1990) found that among Canadian undergraduate students of various ethnic backgrounds, female students had higher depression severity scores and were more likely to be depressed, as compared to men. Likewise, Langhinrichsen-Rohling and colleagues (1998) found that female college students

reported significantly more depressive symptomology on the BDI compared to their male counterparts.

Interestingly, current research has found the prevalence rates for depression to be higher in recently widowed men compared to widowed women (Lee & DeMaris, 2007; van Grootheest, Beekman, Broese van Groenou, & Deeg, 1999). It appears that marriage acts as a buffer against depression for men and upon the death of their spouses men have a hard time adjusting to the change. A study by Lee, DeMaris, Bavin, and Sullivan (2001) found that men's poor adjustment to widowhood and susceptibility to depression were related to decrease in church attendance, difficulty with domestic chores and communication difficulties with their children.

Gender equality in rates of depression has also been found among certain religious groups. In particular, research has found that among members of orthodox Jewish communities the depression rates for men and women tend to be equal, unlike that of the general population. Prevalence studies show this sex difference is not due to a decrease in depression among women; rather it is attributed to an increase in depression among men in these communities (Levav, Kohn, Golding, & Weissman, 1997; Loewenthal, Goldblatt, Gorton, Lubitsch, Bicknell et al., 1995). Similarly, rates of depression have been found to be equal for men and women of the Old Order Amish. However, in this case the equivalent rates of depression can be partially attributed to low rates of mood disorders in the population as a whole as compared to the general population (Egeland & Hostetter, 1983). Moreover, it has been suggested, for both Jewish males and Amish males, that the equal rates of depression may, in part, relate to the low levels of alcohol abuse found in both groups (Egeland & Hostetter, 1983; Levav, Kohn, Golding, & Weissman, 1997). Among Jewish males (and females), excess drinking is socially unacceptable and any alcohol use is forbidden among the Old Order Amish, which results in a greatly reduced

prevalence of alcohol abuse (Gressard & Bainwol, 1988). Although the etiological relationship between the two disorders is not yet fully understood, it is believed, for these two groups of men, that depressive symptoms are not as greatly masked or confounded by alcoholism as they can be in the general population. Thus, it may be that depression among Jewish and Amish men is more likely to be recognized and diagnosed increasing prevalence rates (Egeland & Hostetter, 1983; Levav, Kohn, Golding, & Weissman, 1997; Merikangas & Gelernter, 1990).

In summary, depression is a devastating and debilitating mental disorder that affects a significant percent of the population. It can occur at almost any age and can continue to reoccur throughout the lifespan (Kirby & Keon, 2004). The literature reports that the rate of depression is twice as high among women as compared to men (Bebbington, 1996; Kuehner, 2003). A recent national survey found this 2:1 ratio continues to hold true for Canadians (Patten et al., 2006). However, there are a few unique populations where this preponderance is not always seen, such as the recently widowed, university students and the Amish. Nonetheless, depressive disorders remain a pressing health care concern, particularly for women.

EXPLANATIONS FOR SEX DIFFERENCES IN DEPRESSION

Biological Explanations

A variety of authors have theorised that the sex difference in depression could be explained, at least in part, by differences in biological functioning (see Bebbington, 1996). Early research examined the possibility that changes in female hormones and fertility during puberty, menses and menopause may explain the higher rates of depression in women. Since during these times women experience fluctuations in the hormones estrogen and progesterone and many women also experience mood disorders during these phases, it was thought that increases and drops in hormones would directly affect women's moods. There is mixed evidence to support

this model (Nolen-Hoeksema, 2001). It would appear that the co-occurrence of an increase in depression in women during times of high fertility, such as during puberty, is often influenced by both biology and cultural sex expectations for women. Nevertheless, it would seem that a currently developing neuroendocrine and stress hypothesis, which involves some of the female sex hormones, may offer some biological explanation for the preponderance of depression in women (Bebbington, 1998). However, earlier reviews, such as that by Bebbington (1996) and Nolen-Hoeksema (1990), report that any findings of a biological nature have a tendency to be unconvincing and "unable to translate into psychiatric differences" (Bebbington, 1996, p. 34).

Continuing research on the role of hormones and neurotransmitters in relation to mood has begun to find that some biological differences may at least explain a difference in vulnerability to depression. In particular, research has focused on stress reactions and changes in the hypothalamic-pituitary-adrenal axis (HPA axis) which would have a moderating effect on mood (Nolen-Hoeksema, 2001). Major depressive disorder has been found to relate to dysregulation of the HPA axis. Changes in stress hormones following life events and changes in ovarian hormones during the menstrual cycle can lead to dysregulation in the HPA axis causing it to release overly high levels of other hormones, including cortisol, into the brain. The resulting influx of hormones changes the regulation of other biochemicals that regulate mood and depressive behaviours. This system may be important in understanding sex differences in depression as it appears to be sexually dimorphic, that is it would have systematic differences between females and male. In particular, the focus has been on the effects of ovarian hormones. Studies have found that in humans and animals, progesterone is a modulator of the HPA axis (Young & Altemus, 2004). This may make women particularly vulnerable to stress and depression during certain phases of the menstrual cycles when such hormones are high.

Additionally, continual deregulation of the HPA axis appears to cause potential long-term damage to related areas in the brain (Pariante, 2003).

A review of the literature on sexual abuse, depression, and HPA axis deregulation by Weiss, Longhurst, and Mazure (1999) concluded that childhood sexual abuse could be linked to permanent changes in functioning of the HPA axis that, in turn, would lead to increased vulnerability to stressful life events and depression in adult women. Likewise, a similar review by Van Voorheese and Scarpa (2004) found that childhood abuse (physical and sexual) was related to deregulation of the HPA axis, particularly in women, and that chronic stress in adulthood could continue to damage the HPA axis in these women. Thus, early and significant life stressors, such as sexual abuse in childhood, which is more commonly experienced by women, may lead to increased neurological impairment and vulnerability to depression in adulthood (Finkelhor, Hotaling, Lewis, & Smith, 1990; Weiss, Longhurst, & Mazure, 1999).

Artifactual Explanations

One line of reasoning used to explain the sex difference in depression is the thought that the discordance is an artifact of symptom presentation, measurement and the like. Researchers have questioned whether the difference in depression is traceable to a difference in help-seeking behaviours between men and women. That is, women may be more likely to seek help for the symptoms of depression then men. Indeed this appears in some situations to be the case. A number of studies have found that men typically are less likely to seek help for emotional disorders including depression (Galdas, Cheater, & Marshall, 2005; Moller-Leimkuhler, 2002). However, there are two lines of reasoning that would argue against this. First, the sex difference remains in research settings and in large-scale national health surveys where clients are not self-reporting depression (Gater et al., 1998; Patten et al., 2006). Second, across different countries

and study populations (community and primary care), the 2:1 ratio remains intact regardless of the overall prevalence rate. Thus, even in countries where men have elevated reporting rates for depression the sex difference remains (Maier et al., 1999; Weissman et al., 1996).

It is also speculated that the difference in prevalence rates could be due to differences in recall between women and men in retrospective studies. Perhaps women are better able to remember past incidences of depression. Intuitively this seems plausible. If women are more likely to ruminate it may enable them to have better memories of the events (Nolen-Hoeksema, Larson, & Grayson, 1999). However, once again further research weakens this idea. Although Wilhelm and Parker (1994) found that women were more likely than men to remember incidences of subclinical depression, other authors have found women and men to be equally likely to remember episodes of clinical depression (Kuehner, 1999). Therefore, research indicates that prevalence studies of clinical levels of depression are not likely to be biased by memory. More important however, is the substantiation of sex differences in depression in prospective studies, which are not distorted by memory of the participants. Studies that either measure depression at the time of contact or measure forward from adolescence have continuously found a sex difference in depression rates (Maier et al., 1999). For example, a large prospective study of young adults in Switzerland found a significantly higher percentage of women than men who were classified as having major depressive disorder during the initial, middle and final data collecting phases of the study (Ernst & Angst, 1992).

Moreover, there is concern that the higher prevalence of depression in women is simply due a combination of differential reporting of symptom type or severity by women and diagnostic criteria that might not be tapping into aspects of "male depression" (Kessler, 2003; Moller-Leimkuhler, Bottlender, Straub, & Rutz, 2004). The literature in this area is mixed and

often contradictory. In terms of presentation of symptoms, a number of studies have found men do appear, at times, to endorse different symptoms. Winkler et al. (2004) found men to report more symptoms of affective rigidity, blunted affect and hypochondriasis, whereas women reported more affective liability and dysphoria. Nonetheless, their study did find the overall severity of depression to be equal for both sexes.

In contrast, Kronstein et al. (2000) found that in patients with chronic depression, the symptoms profiles of women and men were generally the same. Hildebrant, Stage, and Kragh-Soerensen (2003) found that, although there were small variations in symptoms most often endorsed, men and women endorsed the same mean number of symptoms. Similarly, a number of other studies have found some minor differences in symptom presentation, in particular somatic and behavioural symptoms such as appetite and substance use. However, the authors of these studies conclude that overall the pattern of symptom endorsement is rather homogeneous (Moller-Leimkuhler et al., 2004; Young, Scheftner, Fawcett, & Klerman, 1990). Lastly, in a particularly interesting new study, Bogner and Gallo (2004) used a statistical measurement model with structural equations that "permits simultaneous estimations of a measurement model ('internal' validity) and the incorporation of external covariates ('external validity')" (p. 128). Therefore, the level of depression, bias of the items, and endorsement across the groups can be compared all at once. Using this model, the authors conclude there were no differences between the depressive symptoms reported by women and men (Bogner & Gallo, 2004). Furthermore, most studies find, regardless of symptoms reported, the severity of overall depression is equal for both sexes (Moller-Leimkuhler et al., 2004; Winkler et al., 2004). As well, the distribution of mild, moderate and severe cases is proportional for both women and men (Hildebrant et al., 2003).

Lastly, some researchers attest that substance abuse, in particular alcohol abuse, in males may be masking more serious depressive symptoms, thus causing men to be under diagnosed for depression and accounting for the sex discrepancy in the rate of depression (Kilmartin, 2005). However, this is a multi-faceted and controversial concept with mixed findings in the literature (Addis, 2008). While some argue that substance use is utilized by some men as a form of self-medication against depression and other negative feelings, women have also be found to do the same (Weiss, Griffin, & Mirin, 1992). Moreover, studies have found that among individuals diagnosed with substance abuse or dependence the risk of having co-occurring mood disorders is greater for women compared to men. Hence even among the specific population of individuals with substance abuse problems women are more likely than men to be depressed (Grant & Harford, 1995; Zilberman, Tavares, Blume, & el-Guebaly, 2003). Thus it would seem, while substance abuse may lead to some underreporting of depression in men it is still not sufficient to explain the preponderance of depression in women.

Therefore, it would seem that the influence of any artifacts would be at most minimal and insufficient to account fully for the sex difference in depression. The premise that the preponderance in depression is due to differences in help-seeking behaviour or recall of symptoms has not been supported (Gater et al., 1998; Maier et al., 1999; Patten et al., 2006). Likewise, differences in the rates of depression cannot be fully attributed to differences in symptom reporting or severity as the research in general has found these differences to be mild or absent (Bogner & Gallo, 2004; Moller-Leimkuhler et al., 2004).

Cognitive-Behavioural Explanations

One theory that does seem to explain at least some of the sex difference in depression is Nolen-Hoeksema's (1987) Response Styles Theory, which implicates rumination as a key

contributor to the amplification and prolonging of depressive episodes, which in turn may lead to more frequent and chronic episodes. Rumination is one possible response to a dysphoric mood state. It is described as a cognitive process whereby the individual turns her/his thoughts inward and focuses repetitively on the situation and meanings of her/his distress. Various authors have found that women, more than men, turn to ruminating as the way to deal with feelings of depression. In contrast, men typically try to distract themselves from a negative mood by engaging in other activities (Kleinke, Staneski, & Mason, 1982; Nolen-Hoeksema, 1990). Rumination is thought to prolong depression in a number of ways. First, rumination appears to affect thinking by increasing negative memory formation, poor self-appraisals and pessimistic attributes. Second, ruminative behaviours are thought to interfere with the undertaking of positive instrumental behaviours, which are positively reinforcing and increase a sense of control. Third, rumination hinders problem-solving behaviours. The negative cognitions distract the individual from engaging in proactive behaviours (Nolen-Hoeksema, 1991). In contrast, distraction is thought to contribute to the improvement of mood and increased problem-solving behaviours (Donaldson & Lam, 2004) As well, Bagby and Parker (2001) found that extroverted behaviours and self-distraction predicted improved treatment outcomes.

It appears that women and men will use distraction to offset dysphoric mood, but at the same time women are more likely to use rumination than men (Strauss, Muday, McNall, & Wong, 1997). So why are women more apt to ruminate as compared to men? In her reviews of the literature, Nolen-Hoeksema draws on a number of possible explanations that center around sex role theories. It is thought that women's propensity to ruminate develops in part from the sex-specific socialization of children. Where boys are directed towards being active and regulating their emotions, girls, in comparison, are brought up to be passive and emotional.

Furthermore, this propensity for contemplation may not be encouraged directly in girls, rather indirectly through the absence of reward and positive reinforcement for activity and gregariousness. Lastly, Nolen-Hoeksema (1990) ties in her theories on rumination with facets of learned helplessness, which is discussed next. According to the author, girls are instilled with the belief that women are naturally emotional and should expect times of depressed mood that are outside of their control. Thus, women are less likely to turn to activity and distraction when they do feel depressed.

Another cognitive-behavioural theory of depression, learned helplessness, is thought to explain some of the sex differences in the rates of depression, when considered within the context of social and interpersonal inequalities that women experience. The basic premise behind the theory of learned helplessness is that people who find they have no control in their environment lose motivation and end up feeling helpless and depressed (Seligman, 1975). It is thought that experiencing uncontrollable situations or outcomes of behaviour leads to motivational, emotional and cognitive deficits that are similar to those seen in depression. However, Seligman's original proposal was based largely on animal models and many felt it was insufficient to fully explain the range and complexity of outcomes seen in humans (Buchwald, Coyne, & Cole, 1978). As a result, the learned helplessness theory was reformulated with an increased focus on cognitive elements, in particular, attributional styles (Abramson, Metalsky, & Alloy, 1989; Abramson, Seligman, & Teasdale, 1978). The reformulated learned helplessness theory proposes that learned helplessness and subsequent depression arises from the ascription to a particular style of attribution given to causes following a negative event. The attributional style is characterised by three bipolar dimensions namely internality (internal-external), stability (stable-unstable), and globality (global-specific). A helpless or depressogenic attributional style

is described as one in which the cause of a negative outcome is perceived as internal to the person (e.g. deficiency in the self), stable across time (e.g. the cause is permanent) and global across situations (e.g. the cause is generalizable across situations and not specific to one situation or event). According to the reformulated learned helplessness theory, someone who explains the causes of a negative event (failures) by using internal, stable and global attributions and explains positive events (success) with external, unstable and specific attributions is at risk for lowered self-esteem and depression (Peterson, Maier, & Seligman, 1993).

Various authors have posited that a combination of female socialization and women's lower social status and power leads to increases in helplessness depression, which can partially explain the sex difference in depression (Kiefer, 1990; Nolen-Hoeksema, 1990; Rothblum, 1982). Part of the problem is thought to lie in the way our culture socializes women. Women are taught from a young age to be more submissive or docile than men, to care more for others then themselves, and to inhibit thought and to remain emotionally expressive but fragile. One study found that the same characteristics were used to describe a feminine individual and a depressed individual. This same study also found the stereotyped description of a married woman was significantly similar to the description of a depressed individual (Landrine, 1988). Likewise, a recent study by Aube, Fichman, Saltaris, and Koestner (2000) found adolescent girls who had high levels of selfless care for others and lower assertiveness had increased depressive symptomology. It is thought that the socialization of helpless and passive behaviours in women increases their likelihood of using negative attributional styles (Kiefer, 1990).

Additionally, helplessness depression is thought to be exacerbated by the powerlessness, social inequality and systemic violence in the lives of women. Poverty, inequality and discrimination have been found to be major risk factors for depression in women (Kendler,

Kessler, Neale, Heath, & Eaves, 1993; Schulz, Parker, Israel, & Fisher, 2001). Women in these situations face stigmatization and blame for their situation, even though the very nature of their situation often undermines attempts to rise up against it (Belle & Doucet, 2003). When women are exposed to these recurring situations of hopelessness and loss of power, it creates in them the sense that they have no of control over such situations, which in turn increases the likelihood that they will adopt a helpless way of thinking. The reinforcement of this learned helplessness in women increases their vulnerability to depression (Nolen-Hoeksema, 1990).

In summary, cognitive behavioural theories appear to be able to explain a proportion of the sex differences in depression. In particular, ruminating behaviours appear to affect the duration and recurrence of depressive episodes and women have been found to engage in ruminating at a much higher rate than men (Nolen-Hoeksema, 1990, 1991). As well, there is some evidence that women are more likely to adopt negative attributional styles when faced with stressors, which can lead to an increase in helplessness depression (Kiefer, 1990; Nolen-Hoeksema, 1990; Rothblum, 1982). Nevertheless, men have also been found to ruminate and adopt negative attributional styles. Thus, these variables also influence depression in males, not just depression in females (Abramson et al., 1978; Strauss et al., 1997).

AN INTRODUCTION TO SOCIAL SUPPORT

The literature on social support and depression is vast and encompasses a myriad of interrelated concepts and formulations. According to early work by Cobb (1976), social support includes information that leads an individual to feel she/he is cared for and loved, esteemed and valued or belongs to a communal network. Since then, the concept of social support has been broadened to include other variables such as instrumental and physical assistance that interact with cognitive appraisals (Sarason, Sarason, & Pierce, 1990). Most contemporary authors agree

that social support is best thought of as a multidimensional concept that encompasses a number of more specific facets of interactional behaviour (Vaux, Riedel, & Stewart, 1987; Weber, 1998).

Structurally, social support has been examined in terms of an individual's social network or level of social embeddedness (Streeter & Franklin, 1992). This can include measures of the quantity and complexity of an individual's social relationships. As well, measures of network can examine the degree of access the individual has to significant others. Embeddedness can also be assessed by the number of different types of social ties, such as peer groups, family, co-workers and neighbours, which an individual could potentially enlist for support in times of need. However, examining only the structure of an individual's support network can result in an incomplete understanding of the quality and satisfaction of the relationship (Barrera, 1986). The support received by different members is not always equally valuable. In particular, spousal support has been found to be particularly important, more so than that from other family members (Pitula & Daugherty, 1995).

In addition to embeddedness, social support is also characterized by resources and aids that an individual perceives she/he has access to and the supportive behaviours that she/he receives from others. Perceived support centers on the individual's subjective perception of the availability of support and her/his satisfaction with these supportive ties. Measures of perceived support focus not so much on the form of the social network but on the degree of satisfaction one has with this network and on the "individual's confidence that adequate support would be available if it was needed"(Barrera, 1986, p. 417). Examining individual perception of support enables variants in the quality of support from different sources to be taken into account. For example, an individual with a small but dedicated support network of family may be more satisfied than an individual with a large but inconsistent network of friends. Moreover, several

studies have found that the subjective appraisal of adequacy and availability of support is a better predictor of well-being then network size alone (Barrera, 1981; Procidano & Heller, 1983). Social support can also be examined in terms of the behaviours that are actually received by the individual in times of stress. Such measures focus on the variety of different actions that one has received under different stressful situations. However, when received social support is studied it is typically done so retroactively. Thus, it may be more appropriate to consider the results "perceived -received" due to retrospective bias in remembering the event (Barrera, 1986). Nevertheless, measures of perceived and received support add a breadth to the concept of social support.

Social support is also often conceptualized and examined in terms of "modes" or types of supportive functions. For example, support has been examined in terms of emotional, instrumental and informational elements (Thoits, 1985). Numerous researchers have conceptualized different aspects of social support based on the function and/or types of supportive behaviours. Although the exact model varies between authors, in general most suggest there are three to six different core modes of support.

In their examination of social support and health related functions, Schaefer, Coyne and Lazarus (1981) describe a triad model of support types that has received empirical support elsewhere in the literature (House & Kahn, 1985). In order to study thoroughly the link between support and health the authors suggest breaking the concept of social support down into three interrelated types of functions: emotional, tangible and informational support. The first, emotional support, includes displays of intimacy and companionship which produce a feeling one is cared for. The second, tangible support, includes behaviours that provide actual services

or aid resources. The third, informational support, centers on the exchange of information, advice and feedback (Schaefer et al., 1981).

Other authors have proposed that there is a need for even finer distinctions among the types of supportive behaviours. Two competing typologies are that conceptualized by Barrera, Sandler, and Ramsay (1981) and by Vaux et al., (1987). Barrera and colleagues suggest that social support is best divided into six categories that include material aid, physical assistance, intimate interaction, guidance, feedback and positive social interaction. These distinctions not only account for the diversity of support available but also allow for the examination of "multiplex" relationships where certain network members fill multiple support roles. To support research on social support using the six modes the authors created the Inventory of Socially Supportive Behaviours (ISSB). However, exploratory factor analysis of the scale revealed a four-factor solution. Thus, the scale appears to be lacking the diversity of items to cover all six proposed modes, or some reformulation may be warranted (Barrera et al., 1981). Similarly, Vaux created the Social Support Behaviours (SSB) scale to support his five-component model of support that includes emotional support, socializing, practical assistance, financial assistance, and advice/guidance. Confirmatory factor analysis of the SSB revealed that the items fell into the five factors as predicted. As well, judges correctly classified the scale items into the five proposed modes further supporting the conceptual design of Vaux's model (Vaux et al., 1987).

In review, social support is best perceived as a multidimensional concept. It can be examined in terms of an individual's social network or her/his level of embeddedness in a community. As well, social support can include those interactions the individual perceives she/he can access if needed that allow her/him to feel connected and loved by others, or it can be a measure of actual actions received in times of stress by the individual. Moreover, the actions

associated with social support can be partitioned into distinct types of support such as Vaux's five-mode model of emotional support, socializing, practical assistance, financial assistance, and advice/guidance (Vaux et al., 1987).

The Interaction of Social Support and Depression

It is thought that social support can have positive effects on health and depression through two different paths. The first is a direct path entitled the "main effects" model which stipulates that social support has a direct effect on depression regardless of the presence or level of stressors (Cohen & Willis, 1985). The second model is a "stress buffering" hypothesis where social support acts as a protective buffer that modifies the effects of stresses and vulnerabilities on depression (Fernandez, Mutran, & Reitzes, 1998). Although there are debates in the literature as to which model is more accurate, it would appear that, depending on the situation, either model could be correct (Cohen, Gottlieb, & Underwood, 2000; Weber, 1998).

The main effects model stipulates that social support has a direct effect on the risk for depression in a number of ways, regardless of the presence of stressors (Cohen & Willis, 1985). First, it is thought that being part of social network influences feelings and behaviours within the individual. The social network acts as a source of information and social control that can elicit positive changes, such as increases in self-care and healthy behaviours, which in turn reduce risk factors of depression (Cohen et al., 2000). This idea relates to social integration theory which proposes that being part of a group or society protects individuals from disordered functioning by discouraging harmful behaviours (such as suicide) and strengthening positive feelings of integration and belonging (Vilhjalmsson, 1993). However, it would seem that the effects of social integration have the potential to be both positive and negative depending on the messages and beliefs received by the individual from their peer group. Social support is also thought to

directly affect depression as a result of the interaction with others which provides general positive affect. The interaction of the self with others can provide stability and a sense of purpose that increases the individual's sense of self worth and value (Cohen et al., 2000). According to the symbolic interactionist perspective, "the self" develops from interaction with others. Thus, psychological wellbeing develops out of the positive identities and self-evolutions that are reflected in close relationships. Additionally, it is thought that a lack of support and interaction can lead to "negative self-evaluations and a sense of meaninglessness" (Vilhjalmsson, 1993, p. 333).

In contrast, the stress buffering model purports that social support works by preventing or decreasing negative responses to stressful events that increase depressive affect (Cohen & Willis, 1985). The research suggests that social support interacts with stress in a number of ways. First, it is thought that social support provides the individual with the perception she/he has resources that can be accessed in times of need. This perception can bolster the individual's confidence in her/his ability to cope and reduce the impact of the stressor. Second, the impact of stressors may be reduced when supportive others act in ways that provide tangible assistance (giving money, child care) to alleviate the strain. This social interaction with others can also distract the individual, if only temporarily, and relieve some of the tension of the stressful situation (Cohen et al., 2000).

Research has found that social support can be an important predictor of the onset and course of depression in both women and men (Heponiemi, Elovainio, Kivimäki, Pulkki, Puttonen, & Keltikangas-Järvinen, 2006). Looking at women specifically, in concordance with the stress buffering model, studies have found that low levels of social support, in combination with stressful life events, predict the onset of future depressive symptomology (Kendler et al.,

1993; Monroe, Bromet, Connell, & Stephen, 1986). In particular, emotionally supportive behaviours have been found to have significant stress buffering effect on the onset of depression (Power, 1988). Additionally, having a larger or more supportive social network has been found to relate to a better depressive course over time. Wildes, Harkness, and Simons (2002) found that, regardless of stressful life events, women with smaller networks were more likely to have elevated symptomology following a one year interval, compared to women with larger networks. Likewise, the number of close supportive relationships has been found to be predictive of remission outcomes and relapse rates in depressed individuals (Brugha, Bebbington, Stretch, MacCarthy, & Wykes, 1997; Cronkite, Moos, Twohey, Cohen, & Swindle, 1998). Moreover, numerous interpersonal, emotional and instrumental aspects of support have been found by women to be useful in the alleviation of depression. Vidler (2005) found that the strengthening of one's social support system, through various means such as breaking isolation, finding work and drawing in closer to social relationships, is an important aspect of the recovery process for women with depression.

However, the benefits of social support and large support networks may come with some negative costs. Not all sources of support are equally beneficial and it appears important for most women to maintain a variety of social relationships (Turner, 1994). In a study that compared sources and types of support received by hospitalized women with depression, Pitula and Daugherty (1995) found that for most modes of support, a woman's spouse or partner and her close relationships were perceived as the most supportive, while her kin members were the least. However, this study also found that, while being a strong source of support, spouses were also perceived as being the source of the most conflict for the women. Similarly, an earlier study by Ladewig, McGee, and Newell (1990) reported that, while spousal support was generally

beneficial in buffering multiple sources of strain related to depression, other sources such as friends and family remained important in helping women cope, in particular in dealing with marital strain. Even so, with most relationships there are bound to be some negative interactions, whither intentional or not, that can create strain and conflict which in vulnerable individuals could increase negative or depressive affect.

Research has found that in addition to receiving more support women are also more likely to be one of the primary sources of social support for others and have more frequent negative interactions with network members as compared to men. Although some of the effects of positive support can cancel out some of the effects of negative supportive interactions, women still remain vulnerable to having the negative aspects surpass any benefits the social network would provide which would increase the risk of depression (Turner, 1994). This situation appears to be particularly salient among women living in poverty. Studies have found that women in these situations find the reciprocal demands of such social relationships to be taxing of already diminished resources, time and esteem, to increase daily stress and do not result in increased personal resilience (Belle & Doucet, 2003; Riley & Eckenrode, 1986; Wasylishyn & Johnson, 1998). It would appear that not all socially supportive behaviours or sources have the same effects on depression and further research would be valuable.

In summary, social support may reduce the risk for and severity of depression in women directly, by improving positive affect and decreasing harmful behaviours. Social support can also work indirectly, by acting as a buffer against the negative impact of stressful life events that lead to increased risks and chronicity of depression (Cohen et al., 2000). Moreover, various elements of social support, including spousal support, size of network and satisfaction with

perceived support, can have a positive effect on the onset and course of depression in women (Brugha et al., 1997; Pitula & Daugherty, 1995).

THE SILENCING THE SELF THEORY OF DEPRESSION IN WOMEN

The Silencing the Self theory of depression in women developed out of the clinical work and research of Jack (1991). According to Jack the traditional explanations and theories of depression provided an insufficient, if not inaccurate, understanding of the depression of her female clients because the "filters" of established theory were preventing women's inner interpretations of their lives from being heard. Within self-silencing theory, the emphasis focuses on the individual's perception of her inner and outer realities, not a predetermined "objective reality" embedded into other theories. It is believed this duality of inner and outer experience is a key factor that affects levels of depression in women. Formally, Jack took a phenomenological approach in investigating depression in women. In simple terms she began to really listen to what each woman was saying. Through the narratives of twelve women Jack began to lace together reoccurring themes that became the basis of her research. Each woman's voice gave light to the subjective context of a very personal experience (Jack, 1991).

According to Jack (1991) and others (see Gilligan, 1982) women are orientated towards a relational sense of self, in which the self develops within the framework of close genuine attachments. This relational orientation develops out of female socialization and culturally prescribed sex roles. Women are viewed as the caretakers and "kin-keepers" of our society. The female role centres on nurturing and raising children, as well as maintaining ties within the family (Salari & Zhang, 2006). Women mature through a process of successive relationships in which varying levels of connectedness are formed. In comparison, men are socialized through a process of separation with the goal of autonomy. The social interconnectedness of women does

not negate having individualized preferences, thoughts or interests; rather such ideals develop from the experiences within relationships. However, our current society places the highest moral and developmental values on independence, individualism, and self-reliance, characteristics that are the archetype of male development. This is the crux of the problem. Women are socialised towards a relational self while at the same time being told it is a weaker and less developed way to be. Moreover, the conventional theories of depression (see Abramson et al., 1989; Beck, 1967) interpret a woman's need for connectedness not as an authentic means for social integration, but as dependency, pathological attachment and an inability to be "independent". Based on an understanding of and effort to balance the conflicting social expectations of our culture, women develop cognitive schemas that dictate how they must act in order to maintain safe intimate relationships, while not acting too "dependant" or "needy" (Jack, 1991).

From her research, Jack (1991) developed the Silencing the Self theory. This theory examines the behaviours and cognitions that heterosexual women enact in order to form and maintain close intimate relationships with men. Unfortunately, the constellation of thoughts and behaviours associated with self-silencing can also lead to hopelessness, loss-of-self and eventually depression. It is not known if this theory will apply to women in same-sex relationships and literature in the area is lacking.

According to Jack (1991, 1999), women are fostered by cultural influences to develop rigid and particular standards that they feel they must adhere to in order to secure their intimate relationships. Their self-image and self-esteem become enmeshed in a series of unattainable, counter-productive rules for sustaining intimacy within the male-dominated hierarchy of marriage. To meet the demands of self and society, women invent an inauthentic version of self that they can present as the "good wife", and the supportive caretaker of husband and children.

This myth of marriage "promises intimacy, identity and a well marked life path" but in truth leads to "a reduction of confidence, of possibilities, of 'self'" (Jack, 1991, p. 44). Women deny their own personalities, interests and goals in a futile attempt to align themselves with their partners and secure their relationships. On the outside these women appear as "superwomen", juggling their prescribed roles at home and in the workforce, effortlessly and with flair. While on the inside, these women feel like they are losing touch with their authentic selves. Unfortunately, an inauthentic self can only lead to an inauthentic intimacy in the relationship. What begins as a striving for oneness and a secure bond ends up being a sacrifice of the self in favour of maintaining the husband's preferences and a fabricated bond.

Women also develop what Jack (1991) calls "the Over Eye" as part of their inner dialogues. The Over-eye is a condemning inner voice that speaks with the morals and judgements of society. It tells the true self, or the "I", what the woman shall do, cannot do and better do. The Over-eye follows the cultural dictates of femininity and presents itself as goodness and right. In a woman's mind, it creates and maintains the schema of "the good wife" and what is required in order to maintain the relationship. This ideal includes having to self-sacrifice, put the needs of others first, always be kind and never be angry. If left unchecked, this dictating, ruminating Over-eye will overrule the thoughts of the authentic self. The process leads women to judge and condemn their own thoughts and perspectives. Additionally, the Over-eye declares any failure to live up to these prescribed standards to be the woman's fault; she is too weak, selfish, and foolish and does not deserve to be loved. This constant condemnation of the Over-eye and its conflicts with the authentic "I" weakens one's self-esteem and leads to a divided sense of self.

How do women come to adopt and internalize the moralistic and judgemental schemas of femininity touted by the Over-eye? As Jack (1991) explains, women are socialized from childhood to develop and internalize a set of morals derived from their connection in the mother-daughter relationship. Unlike boys who are taught to identify with separation and independence from their mothers or caregivers, girls retain a constant connectedness or identification with the mother. Through this bond, women also internalize how they perceive their mothers to interact with other people, in particular with their husbands.

Girls are taught that there are ways to interact with men and different ways to interact with other women and children. Daughters see their mothers deferring to their father's needs or conceding to patriarchal rules and they internalize this behaviour as the way to interact with men. Further, the messages of sexual inequality and women's secondary role are reinforced by the broader cultural norms. Unfortunately, these rules of conduct become internalized so ubiquitously during the formative years that, even if a young woman comes to feel they are wrong for her, it is hard for her to risk change. There is still the fear that stepping away from the culturally prescribed traditional roles for women will result in the loss of love and security (Jack, 1991, 1999). This fear can be quite genuine when one further considerers the myriad of domestic and systemic violence that women are subject to in a much greater proportion then men (Greenan, 2005). For many women, not being subservient to the patriarchal rule of their husbands comes with the real risk of spousal abuse (Weisz, Tolman, & Saunders, 2000). Moreover, a woman's attempt at separation or divorce can also be met with violence. For example, Kurz (1996) found that, among women who experienced violence during their marriage, many continued to experience violence from their spouse during and after the separation and while attempting to negotiate for a share of the resources from the marriage. As

well, divorce can have negative economic and social impacts on women. Many women see a sharp decrease in household income. Albeit, , the economic hardships faced by these women can be offset by the availability of proper support systems (Arditti, 1997). Nevertheless, these fears of increased hardship and poverty further reinforce the behavioural pattern of the submissive and self-silencing wife, which often leads to frustration, anger, sadness and even depression (Smith, 1997).

Moreover, to maintain these standards of "good" as dictated by socialization, culture and the Over-eye, women must actively work to control their outward actions and silence their own authentic thoughts. When a woman self-silences she subordinates her own voice (literally and figuratively), denies her own perceptions, censors her every thought and hides her feelings from others and herself, all in an attempt to maintain her relationship. Although a woman's self-silencing may cause her to appear dependant and compliant on the outside, on the inside it is a constant cognitive struggle to maintain this façade. She must deny whole parts of self and voice in order to maintain the outward image of selflessness and grace. The woman accomplishes this by separating herself from her true feelings and condemning any actions she believes would not be approved of by those around her.

Self-silencing is more than self-censoring or avoidance. Figuratively and often literally, there is an active "silencing" of any thoughts, feeling and actions believed to go against the status quo. It becomes the woman's responsibility to keep harmony in the relationship through the denial of any thoughts that may "rock the boat" (Jack, 1991, p. 129). It is believed that conformity to the feminine ideal will secure the relationship and garner acceptance from those around her. It is a constant struggle between the Over-eye and the authentic I, with every "win" of the Over-eye causing more of the true self to be hidden. The self becomes divided between

what a woman knows and feels from her lived experiences and her acceptance of the values of a male-dominated society. Through this internalized struggle, women develop a sense of hopelessness that the true self will never be heard and that the modeled self will never be good enough.

According to the Silencing the Self theory (Jack, 1991), in the process of self-silencing women also come to devalue their own beliefs and ideas which further heightens in them the sense of a "lost" or divided self. There is a distancing between a woman's own feelings and those she feels are acceptable to society. On one side, women have internalized and accepted the self sacrificing feminine role they are expected to play. On the other hand, their lived experience and secret hopes and feelings tell them they are women who are deeper and more complex then what they have come to act out in their relationship. Women become split between the two facets of self with no foreseeable way to pacify both. Thus, the lively authentic self is then condemned and buried in favour of what a woman "should" do as she re-enacts the "female rituals expected by the culture- self-silencing [. . .] to capture male approval" (Jack, 1991, p.134). This disconnection leads to decreases in self esteem and feelings of hopelessness and frustration. These negative states leave women vulnerable to a cycle of self-silencing, continuing loss of self and depression.

In summary, Jack believes that, for many women, depression arises out of the cycle of silencing the self. Women develop with a relational sense of self and thus place extreme importance on the maintenance of relationships, in particular those of an intimate nature. However, through feminine socialization, cultural messages and personally enforced standards women develop cognitive schemas whereby in order to create and maintain the desired relationships they feel they must silence their own thoughts and feelings and adopt an outwardly

compliant and passive persona. However, this self-silencing creates a feeling of divided or lost self, decreases self-esteem and increases a sense of hopelessness, which can lead to depression. The depressive affect and hopelessness in turn increase self-silencing behaviours (Jack, 1991).

Silencing the Self and the Silencing the Self Scale

Jack, (1991; Jack & Dill, 1992) developed the Silencing the Self Scale (STSS) to enable research on the association between the behaviours and beliefs of self-silencing and depression in the relationships of women. The STSS consists of 31 items that recapitulate the "specific images of the self in intimate heterosexual relationships . . . heard most often in the narratives of depressed women" (Jack, 1991, p. 122). The items focus on the moral meanings women attach to the behaviours enacted in their relationships in an attempt to secure intimacy. For example, item # 3 "Caring means putting the other person's needs in front of my own" not only asks for an endorsement of the female role but also examines the moral "shoulds" believed to be necessary to sustain an intimate relationship. Participants are asked to rate each item on a 5-point scale; from 1-strongly disagree to 5- strongly agree. The scale is divided into four subscales, which were rationally derived and believed to correspond to the dynamics of depression proposed by Jack (1991). Although each subscale is representative of a distinct concept they are inter-correlated and strengthening aspects of one should improve the others. Higher scores are indicative of greater self-silencing. The subscales include:

1. Externalized Self-Perception (judging the self by external standards). This subscale examines the cultural morals and standards used for the negative judgement of self. For example, item # 7 reads as "I feel dissatisfied with myself because I should be able to do all the things people are supposed to be able to do these days".

2. Care as Self-Sacrifice (securing attachment by putting the needs of others before the self). This subscale examines the behaviours and beliefs associated with putting one's self last. For example, item # 4 states "Considering my needs to be as important as those of the people I love is selfish".
3. Silencing the Self (inhibiting one's self-expression and action to avoid conflict and possible loss of relationship). This subscale examines the schemas associated with self-silencing and loss of voice. For example, item # 2 reads as "I don't speak my feelings in an intimate relationship when I know they will cause disagreement".
4. Divided Self (the experience of presenting an outer compliant self to live up to the feminine role imperatives while the inner self grows angry and hostile). This final subscale reflects the phenomenology of loss of self and depression. For example, item # 17 states "In order for my partner to love me, I cannot reveal certain things about myself to him/her" (Jack, 1991, p. 216).

In order to garner more qualitative information for further research into the standards depressed women set for themselves, the final item on the STSS has been designed to enable participants to elaborate on their answer. The item reads "I never seem to measure up to the standards I set for myself" and then asks those who agree or strongly agree to list up to three standards they are not meeting. Jack (1991) found the answers from three distinct groups of women (college students, women residing in shelters for battered women and new mothers who abused cocaine while pregnant) were all very similar. Additionally, the standards listed by a sample of men were different from those reported by women. The standards from the women's list are representative of the cultural imperatives that women most often reproach themselves for and include such things as failing to live up to standards of "the good wife", attempts at

maintaining a culturally dictated ideal appearance, not being financially independent, and being unable to sustain the "superwoman" persona at home and at work. Additionally, some women even report a distinct hopelessness in their response to the last time, having given up because they feel unable to reach such hefty goals. As one participant writes "I've quit setting standards because I feel like nothing" (Jack, 1991, p. 124).

Jack's (1991) Silencing the Self theory of depression has some commonality with Beck's (1983) theories of depression, including an emphasis on underlying cognitive schemas. The BDI and the STSS have been found to correlate across different levels of depression and in a number of different samples (Jack & Dill, 1992). However, Jack varies significantly from other theories of depression in her perception of the role of the individual and her/his interaction with the environment that leads to depression. Where mainstream theories of depression are based on cognitive deficits (e.g. Beck, 1983), negative personal characteristics, or personality deficits (e.g. Abramson et al., 1989), Jack's Silencing the Self focuses on a phenomenological model to understand depression in the individual. In a phenomenological approach the focus turns to gender specific socialization in which "the categories of thought that people bring to actively interpret their worlds, guide their behaviour, and assess the self are socially constructed and are reflexive with social institutions and contexts" (Jack & Dill, 1992, p. 99). Accordingly, the interaction between the behaviours of self-silencing, as measured by the STSS, and a woman's endorsement of these schemas leads to increases in the individual vulnerability to depression.

Additional Research on the Silencing the Self Scale

Since the introduction of Jack's (1991) Silencing the Self theory of depression, subsequent studies have examined the consequences of self-silencing and tested Jack's conclusions of the theory. In particular, a growing body of research has specifically examined

the construction, reliability and validity of the STSS for use with a variety of populations. The findings of these studies are often mixed, depending on the sample used. However, most of the studies provide continuing support for Jack's STSS (Jack & Dill, 1992). A number of these studies will be discussed below.

One of the first follow-up studies on the STSS was conducted by Thompson (1995). This study examined the construct validity of the STSS with women and men, as well as the interaction of self-silencing and depression on intimate relationship adjustment. In terms of validity, the STSS was found to correlate significantly with depression scores, as measured by the BDI, in women (r= .56) and men (r= .33). However, as predicted by the author (Thompson, 1995) and by Jack's theory (1991) the correlation between self-silencing and depression was significantly higher for women. Additionally, hierarchical regression of depression on the three study variables (demographics, relationship satisfaction and self-silencing) found that self-silencing accounted for much more of the variance in depressive symptomology for women (19%) than for men (10%). Moreover, demographic variables (such as employment and income) accounted for 30% of the variance in depression scores for men, whereas the same variables accounted for a non-significant 4% of the variance in depression for women. So it would seem that there are significant differences in the relationship between self-silencing and depression for each sex. Interestingly, when Thompson (1995) compared the results of couples where both members participated in the study she found that the male partners reported higher STSS scores than the women but that self-silencing in men did not correlate with depression or marital adjustment. In contrast, self-silencing in women was negatively correlated with marital adjustment and positively correlated with depression scores. Thus, although men report more self-silencing it does not seem to be related to depression and adjustment in the same way as it is

for women. The author suggests that the way men interpret the items on the STSS and the significance that silencing the self holds in relationship functioning may be different from that for women. In particular, men may interpret the items on the STSS as behaviours of "stonewalling" in which they use silence and avoidance as ways to control the relationship.

In an attempt to further understand the sex differences in silencing the self, Page, Stevens, and Galvin (1996) examined the relationships between self-silencing, depression and self-esteem in a sample of female and male undergraduates. As in the previous study, men in this sample reported significantly higher scores on the STSS. In particular, when each subscale of the STSS was examined individually, men scored higher on all of the subscales except Externalized Self-Perception. The correlation between STSS and depression as measured by the BDI was significant for both women (r= .44) and men (r=.33). Although there was no significant difference between the sexes, the authors noted that a high score on the STSS might represent different sets of concepts for men and women. For example, where self-silencing behaviours for men might be influenced by needs for power in the relationship, in women they might be influenced by needs for maintaining harmony in the relationship. Furthermore, the authors found that the level of self-esteem moderated the link between self-silencing and depression. For individuals with low levels of self-esteem, self-silencing had an effect on depression but there was no significant effect for those with moderate or high self-esteem. It would seem the results of this particular study contradict Jack's theory and other previous findings (Jack & Dill, 1991; Thompson 1995). However, the study design did have some particular weaknesses that could slant the results. Primarily, the sample used in the Page and colleagues (1996) study was not congruent with the type of individuals who are typically thought to self silence. This sample was composed primarily of single individuals, where Jack's theory

is aimed primarily at women in intimate relationships, and most of the participants had minimal depression scores, which would make it difficult to apply the results to individuals with moderate to severe levels of depression (Page et al., 1996).

A number of studies (Cramer & Thoms, 2003; Duarte & Thompson, 1999; Remen, Chambless, & Rodebaugh, 2002; Stevens & Galvin, 1995) have also been conducted to investigate the item loadings of the four rationally derived subscales of the STSS. Such studies have presented a variety of suggested reformulations for each subscale, although, in general most of the studies confirm the relative adequacy of Jack's (1991; Jack & Dill, 1992) original subscales.

In one of the earliest follow-up studies, Stevens and Galvin (1995) tested the four-factor structural model of the STSS with a group of college women. Their results suggested an item structure very similar to Jack's original construction, with a few minor changes. In particular, item 11 failed to load onto (or belong to) any of the four scales, item 26 loaded onto two scales, and 3 additional items loaded onto different scales then originally suggested. The authors recommended that these few items be regrouped and that item 11 be eliminated, but confirmed the overall structural integrity of the STSS (Stevens & Galvin, 1995). Likewise, a study by Duarte and Thompson (1999) confirmed similar results. These authors found that, for women, a four-factor solution presented the best fit for the items and that this solution accounted for 44% of the variance between self-silencing and depression. They too recommended a small number of changes to the STSS. Specifically they suggested changes to the placement of particular items onto different subscales and they also recommended dropping items 1, 11, and 20. In addition, Remen and colleagues (2002) conducted an exploratory factor analysis in which they found item loadings that replicated Jack's original four factor design for women. However, the same items

loaded onto a four factor model differently for men, which resulted in the need to reformulate the conceptualization of the subscales for men. This revised formulation would include a new factor labelled "autonomy/concealment" (Remen et al., 2002, p. 154). According to the authors, this new factor "appeared to represent an intention to prioritize one's own needs and to maintain a feeling of self-sufficiency" and, in part, indicates that the way men conceptualize the STSS may be fundamentally different from women.

A number of studies have also examined the relationship between silencing the self and race/ethnicity (see Carr, Gilroy, & Sherman, 1996; Gratch, Bassett, & Attra, 1995). These studies are particularly important as they increase the generalizeability of the STSS for use with diverse groups of women. Given that the initial development of the theory was based on the narratives of Caucasian women and the preliminary studies of the STSS were based on predominantly Caucasian samples, (Jack, 1991; Jack & Dill, 1992) the Silencing the Self theory may have limited applicability for use with women of other ethnic backgrounds. In particular, differences in the social contexts, roles and relationship values of women from differing backgrounds may run counter to the underlying assumptions of silencing the self and negate its validity for certain groups of women.

Gratch and colleagues (1995) compared depression scores on the BDI and STSS scores across sex and ethnicity in a college sample. Participants were African American, Asian/Asian American, Caucasian and Hispanic. This study revealed a number of interesting findings. As in the Thompson (1995) study, men in this study scored higher than women on the STSS, even though women were more depressed than men. Analysis of the main effect for ethnicity found that Asian/Asian Americans had significantly higher levels of self-silencing when compared to the levels in the three other groups. As well, Asian/Asian Americans have the highest depression

scores, which were significantly higher than the scores of the Caucasian group. Correlation analysis found self-silencing and depression to be significantly correlated for all groups and sexes (total r= .45). In particular, the correlations between depression and self-silencing were highest for minority women, with African American women having the highest correlation between depression and self-silencing (r= .63; Gratch et al., 1995). The authors concluded that further study is needed to understand the associations between sex, the social constructs of gender, ethnicity and silencing the self.

A subsequent study on the differences in depression and self-silencing as moderated by race found somewhat contradictory evidence when more complex analyses were used (Carr et al., 1996). This particular study compared a group of Caucasian women to African American women from a local college. Both groups of women had similar mean scores on the STSS and the BDI, and scores on each were significantly correlated. However, Caucasian women had a significantly stronger correlation between the two variables (r= .65 compared to r= .28), which is contrary to the results of Gratch and colleagues (1995). Thus, a regression analysis was used to further examine the moderating role of race. This analysis revealed that, although self-silencing and BDI were correlated for both groups, self-silencing was a significant predictor of depression only for Caucasian women. The authors concluded that the STSS is a valid measure of the cognitive schemas associated with self-silencing, at least for Caucasian women. However, further investigations into the relationship between self-silencing and depression are needed, in particular examining situations when self-silencing does not directly influence depression. This might have implications for the understanding of protective factors that might mitigate the link between self-silencing and depression.

In summary, subsequent research on Jack's STSS (Jack & Dill, 1992) has found the scale to accurately measure the facets proposed by the Silencing the Self theory of depression. Nonetheless, some important considerations have become known as a result of this research. In particular, the link between self-silencing and depression seems to be significant for women. However, there seems to also be a relationship between self-silencing and depression in men. Although it appears this phenomenon may be due in part to differential interpretation of the items by men, it remains that some form of self-silencing appears to be enacted by men (Thompson, 1995) possibly to stonewall and control the relationship. In addition, the use and interpretation of the STSS with different groups of women must be taken with caution as it appears that self-silencing may not be an equal predictor of depression for all women. Continuing research with different groups of women and men is warranted (Gratch et al., 1995).

Research Utilizing the Concept of Self-Silencing

A variety of studies have examined the relationships between silencing the self and other variables such as life stress and anger. Since the correlation between self-silencing and depression is not perfect, it is understood that there must be other intervening variables that can modify the relationship. This is particularly true when considering a number of points. Not all women who are depressed engage in self-silencing (Ali, Oatley, & Toner, 2002), not all women who self-silence become depressed (Carr et al., 1996) and men appear to use in their relationships some form of self-silencing which is correlated to mild levels of depression (Thompson 1995). The following studies have examined the links between self-silencing and depression in a number of ways.

One study by Thompson, Whiffen, and Aube (2001) examined the relationship between self-silencing and perceptions of one's parents and partner. Since Silencing the Self theory is in

part an interactional theory, it is important to understand how the depressed individual perceives the behaviours of important others in their lives. For this particular study the perceptions of women and men were examined. First, participants' perceptions of their parents as being cold and distant were correlated to the four subscales of the STSS. Surprisingly, for women none of the subscales related to the perceptions of their parents. However, for men scores on the Divided Self subscale were positively correlated to feelings that their fathers had been cold and distant in childhood. It is suggested by the authors that although women do not relate their self-silencing to rejection from maternal figures, it is still likely they learn to model such behaviours through interaction with passive and submissive mothers. On the other hand, men did associate a cold and rejecting father with a divided self and it is likely this paternal pattern has a strong influence on the male tendency to hide emotions and fake compliance. Secondly, the study examined current levels of self-silencing and perceptions of one's current partner as being critical and intolerant. In women and men, perceiving one's partner as critical was strongly associated with self-silencing. These results would suggest that behaviours including inhibiting one's thoughts, being complaint, passive and self-judging are used by both sexes as a means to deal with a critical partner. However, it may be also true that individuals who use these behaviours in their relationships are more likely to end up with a critical partner and further research is needed.

In one of the few studies of self-silencing to use a clinical population, Ali and colleagues (2002) examined the relationship between life stressors, self-silencing and depression. According to reviews by the authors, the domain of meaning from which one derives a sense of self and related life stressors can have an effect on depression. Of the women who participated in the study, about half were diagnosed as clinically depressed. Additionally, all of the clinically depressed (but not all of the non-clinically depressed) women reported experiencing a major life

stressor in the year prior to the study. For the women in the study the top primary domains of meaning were relational and self-nurturing. Furthermore, both domains were significantly associated with self-silencing. However, in terms of life stressors associated with the primary domain of meaning, relational stressors (stress that comes from interpersonal interaction) had a significantly higher correlation to self-silencing than self-nurturing stressors (stress related to personal activities). Thus it would appear that, regardless of the primary domain of meaning, relational life stressors increase the risk for self-silencing. The authors also compared the level of self-silencing and depression at intake to post-treatment levels of depression and found that those with the highest levels of self-silencing had the least improvement post-therapy. The results of this study emphasise the need for practitioners to attend to self-silencing behaviours and the precipitating stressors that may increase such behaviours in women.

Carfagnini (2005) examined links among anger suppression and expression, and self-silencing. The results of her study found that, among other things, anger suppression, anger expression and elevated self-silencing was related to the severity of depression in the women. This research is supportive of Jack's proposal that women will use self-silencing as a way to consciously keep anger out of their relationships (Jack, 2001). As the results of this recent study indicate, it is likely that increased anger and self-silencing affect the severity of depression in women.

Limitations of the STSS

Although Jack's (1991) Silencing the Self theory of depression in women is derived from empirical evidence and is gaining a growing body of supportive research, there are still a number of possible limitations of the theory which have not been fully explored in the research thus far. Some of the more pertinent of these concerns will now be examined in a brief discussion.

One of the most obvious considerations is the use of the STSS with men. Even though the Self-silencing theory and the STSS were developed drawing on the female experience to explain and measure depression, the scale itself has been used with men, albeit with mixed results. Various studies have found that men frequently score higher than women on the global scale and most of the sub-scales of the STSS. As well, these studies have found that self-silencing in men does correlate with depression but not always to the same degree as with women (Duarte & Thompson, 1999; Gratch et al., 1995; Thompson, 1995). Together, these results would indicate that the STSS is related to depression in men as well as women but not necessarily to the same degree. However, analyses of the STSS have also found that the items on the STSS and their relationship to depression may not hold the same meanings and values for men as they do for women. For example, Ramen et al. (2002) performed a factor analysis on the STSS for women and men and found that the solution for women replicated those of Jack's original model but they did not find the same thing for the male results. Instead they found, that for men, a new factor emerged in the place of Divided Self, which they labelled Autonomy/Concealment. The items on this potential subscale were indicative of a need for self-sufficiency and the maintenance of one's own priorities, which are counter to many of the key components of the original self-silencing theory as it pertains to women. Many of the authors reason that it is likely that men interpret the items differently than women. In particular, it is felt that self-silencing for men is more of a control or stonewalling strategy in a relationship instead of an attempt to secure the relationship as it is for women (Jack, 1999; Thompson, 1995; Ramen, et al., 2002). Thus it would seem there is some potential for using the STSS with men but it is not the equivalent of using the STSS with women as it was intended.

Another concern with the Silencing the Self theory pertains to its use with women of diverse ethnic backgrounds. Jack's original work involved predominantly Caucasian women and from this early work alone it is uncertain how the self-silencing theory and the STSS would apply to women of different ethnicities (1991; Jack & Dill, 1992). Be that as it may, continuing research has begun to examine this issue and, at present, the results indicate that the STSS is acceptable for use with women from a number of different ethnic backgrounds. A study by Gratch et al. (1995) included four groups of women (African American, Asian American, Caucasian and Hispanic) and the results showed that STSS scores were significantly related to depression for all four groups. Interestingly the highest correlations were for women of African American and Hispanic descent, with the former being significantly greater than the correlation for Caucasians. Likewise, a study that examined a Caribbean-Canadian sample of women found that high scores on the STSS correlated with depression (Ali & Toner, 2001). In contrast, a study by Carr et al. (1996) that compared a group of Caucasian women to a group of African American women concluded that self-silencing "was not a significant predictor of depression for African American women" (p. 384). Although further research is needed, based on the work so far it would seem that self-silencing theory does apply to women from a variety of ethnic backgrounds.

There is also some uncertainty pertaining to the applicability of self-silencing theory to women in same-sex relationships. Jack's (1991) original work was with women in heterosexual relationships only. To our knowledge there have been no studies to date that have expressly looked at self-silencing among lesbian women. Even though it is likely that some lesbian women have been included in past studies, because some studies used large samples of women

without clarifying their sexual orientation, no conclusions can be drawn at this time (Gratch, et al. 1995; Ramen et al. 2002).

Thirdly, there may be some limitation to the applicability of the Silencing the Self theory with more recent generations of women whose beliefs may be different, because of changes in cultural imperatives, when compared to the women on which the theory was based. Studies have found more women are adopting less traditional sex role beliefs. In particular, women increasingly endorse more egalitarian beliefs about marriage, family and employment (Amato, Johnson, Booth, & Rogers, 2003; Cichy, Lefkowitz, & Fingerman, 2007). Nevertheless, women still appear to be influenced by traditional sex role beliefs within our culture. For example, women are still required to sacrifice work outside the home, as evidenced by the type and hours of employment and the patterns of unemployment, in favour of looking after the family (Maume, 2006; Stone & Lovejoy, 2004). As well, compared to men, women continue to spend more time doing housework and have less leisure time for personal activities (Bittman, England, Sayer, Folbre, & Matherson, 2003; Bittman & Wajcman, 2000; Mattingly & Bianchi, 2003). Moreover, very recent studies using the STSS found that the correlation between self-silencing and depression remains significant, which also attests to its current relevancy (Thompson, Whiffen, & Aube, 2001; Uebelacker, Courtnage, & Whisman, 2003). Thus it appears that traditional sex role beliefs and societal pressures still have a significant impact on women and that Jack's (1991) theory is still pertinent today.

General Summary on Self-Silencing

According to Jack's Silencing the Self theory (1991), women will resort to using self-sacrificing and self-silencing behaviours that lead to depression in an attempt to secure their intimate relationships. The divided sense of self that arises out of the subjugation of one's own

thoughts, ideas and needs through self-silencing lowers self esteem and increases internalized anger. These women in turn feel "lost" and hopeless, which only leads them to further engage in these behaviours in the attempt to hold onto what little sense of self is left tied up in their relationship. Studies have supported aspects of Jack's theory and found that self-silencing and depression are correlated in women. However, it is not a perfect relationship. It appears there might be other variables that moderate the link between self-silencing and depression in women. Given the relational nature of the Silencing the Self theory, it seems plausible that other relationship variables, such as social support outside of the intimate relationship, may be one such moderating variable. Moreover, the literature indicates that various aspects of social support can effect depression in women. Thus it may be that Jack's theory can be further understood by examining the relationships between self-silencing, social support and depression in women.

THE PRESENT STUDY

Rationale

The Silencing the Self theory proposed by Jack (1991) to explain the high rate of depression in women appears to have some merit. The narratives of many depressed women in intimate heterosexual relationships express similar concerns relating to a loss of voice and sense of self. Studies have found that self-silencing, as measured by the STSS, is correlated with depression. In particular, higher self-silencing scores in women are associated with more depressive symptomology. However, the relationship between the two is not necessarily direct nor can self-silencing explain all depression in women. That is to say not all women in intimate relationships who self-silence become depressed and not all depressed women self-silence. Furthermore, research has also found that men self-silence in their relationships to an equal or

greater degree than women. Many authors suggest this finding is due to the differential context applied to silencing behaviours by men.

Thus it would seem reasonable to assume there must be other variables that moderate the link between self-silencing and depression in women. One possible variable is social support. According to the literature, social support can have a positive effect on depression, in particular as a buffer against stressful life events. Thus social support may moderate the effects of self-silencing on depression.

Objectives and Hypothesis

There were two parts to the present study. The first part adopted a quantitative paradigm. It was designed to investigate the role that social support might play in moderating the relationship between self-silencing and depression. The types of social support investigated were the amount and satisfaction with the emotional and practical support received from different sources (partner and others, where "others" refers to individual outside of the intimate relationship such as family or friends). It was hypothesized that when social support was low, self-silencing would predict depression such that high self-silencing would be significantly associated with greater depression. However, when social support was high, the relationship between self-silencing and depression would be significantly weaker.

The second part of this study was a qualitative investigation that involved a number of focus groups. The objective was to add depth of meaning by contextualizing the quantitative information obtained from the first section and to find out why women self-silence or do not self-silence in their intimate relationships and how that relates to other elements such as social support outside of the relationship. A number of issues were targeted for discussion. They included the importance of emotional support and practical assistance received from different

sources, how the support influenced the women's psychological status (depressive symptoms), the meanings that the women ascribed to their receiving or not receiving sufficient emotional and instrumental support from their partners and from their friends, and how the women dealt with insufficient emotional or instrumental support from their partners and others.

METHOD

Recruitment

During the initial recruitment for Part 1 of the study, women were recruited from Lakehead University, Confederation College and the general community of Thunder Bay. In an effort to get a diverse sample, recruitment took place through a variety of different sources within the University and the community. Within the University, recruitment advertisements (see Appendix A) were placed in the Community Bulletin, which was emailed out to the students and faculty. Undergraduate Psychology female students were also recruited. With permission from the course instructors, female students from two on-line summer psychology courses were invited via email to participate in the study (see Appendix B). As well, recruitment posters (see Appendix C) were placed on bulletin boards around the campus. Recruitment also took place at Confederation College after securing permission and ethics clearance from the Student Union to post the recruitment posters (see Appendix C) around the campus.

Recruitment within the general community was carried out through a number of community sources including day care centers, grocery stores, pharmacies and community resource organizations such as PARO, which is a non-profit grassroots organization that provides services to women and their families to help them achieve economic independence. Contact was made with these various organizations by a phone call or in-person visit (see Appendix D) or by formal letter if necessary (see Appendix E) to management requesting permission to post

recruitment posters (see Appendix C) and brochures (see Appendix F). Finally, a print announcement asking for participants was placed in the Helping Hands section of the Chronicle Journal that posts non-profit events and opportunities to volunteer in the community (see Appendix G).

Following an initial phase of recruitment from the Thunder Bay area it was determined that more participants were needed and so the questionnaire portion of the study was opened up to women from across Canada. To facilitate this additional recruitment, an email was sent to subscribers of the Canadian Psychological Association Section for Students that contained the same information that was sent out through the Lakehead University Community Bulletin (see Appendix A) and through word-of-mouth.

Interested individuals or those seeking more information were directed to a companion website for the study at *http://psychologystudy07.googlepages.com*. Alternately, they could contact the researcher at the email address provided (*psychologystudy07@gmail.com*). Criteria for participation included the following:

a. Participants had to be in a heterosexual relationship with an intimate partner, for no less than 12 months prior to the start of the study, and had to be living with their partner at the time of the study.
b. To avoid methodological confounds, participants had to be free of medical or neuropsychological condition or medication that could account for the symptoms of depression.
c. Participants had to be between 18 and 45 years of age.

Measures

For the quantitative phase of the study, participants were given the following measures in the form of a research questionnaire:

Background Information (see Appendix H, Section A)

Information pertaining to each woman's age, education, employment and ethnicity was gathered. This section also asked for information about the women's current relationship status and family situation. The women were also asked if they had been feeling sad or "blue" in the two weeks prior to participating and if this mood was due to current medical issues or medications. This was done in order to help identify any confounding medical or neuropsychological conditions among the participants.

The Hamilton Depression Rating Scale (HAM-D; Hamilton, 1960; see Appendix H, Section B)

The HAM-D is a 21-item self-report measure widely used to measure the severity of depression symptoms and can be used to monitor changes in the symptoms over time (Kobak, Reynolds, Rosenfeld, & Greist, 1990). Scoring of the HAM-D is based on the total score from the first 17 of the 21 items, which are a measure of depression severity. The remaining four items (# 18-21) are administered to provide extra information for the practitioner, although they do not add to the assessment of severity (Hamilton, 1960). In his original work, Hamilton (1960, 1967) did not stipulate specific cuff-offs for scoring the HAM-D although the scale is designed such that higher scores reflect more severe depression symptoms. However, later research was conducted to try to establish cut-off points that differentiate among different levels of clinical significance and severity. Grundy, Lambert, and Grundy (1996), examined the reliability of cut-off scores that could differentiate between the scores of the general population, outpatients and inpatients. They found that scores under 11.28 were representative of the general population,

scores over 20.99 were representative of inpatients and the scores of outpatients fell between these two points. Müllër, Szegedi, Wetzel, and Benkert (2000) reported on cut-off scores that could be used to differentiate levels of severity, with scores of 16 or greater indicating moderate symptomology and scores greater than 28 indicating severe symptomology. However, it is not uncommon for individual studies to establish their own cut-off scores (see Brown et al., 1995; Stewart, McGrath, & Quitkin, 1992).

Since its development, numerous tests of the psychometric properties of the HAM-D have been conducted. In general the scale is considered to have sound reliability and validity (Rehm & O'Hara 1985). For example, Reynolds and Kobak (1995) tested the psychometric properties of the HAM-D and found the measure to have excellent test-retest reliability (r = .96). They also found the scale had a reliability alpha of .92 and inter-item correlations that ranged from r = .26 to .89. In addition, the HAM-D was found to correlate well with other measures of depression. For instance, Hotopf, Sharp and Lewis (1998) found that the HAM-D correlated strongly with Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) at r = .77, and with the Revised Clinical Interview Scale (CSI-R; Lewis, Pelosi, Araya, & Dunn, 1992) at r = .79.

For the present study, the first 17 items of the HAM-D were included in the research questionnaire. This provided a total score indicating depression severity for each woman. The women's scores can be compared on a continuum, with higher scores reflecting more severe levels of symptoms.

The Silencing the Self Scale (STSS; Jack, 1991; see Appendix H, Section C).

The STSS was developed as a means to measure gender-specific schemas that are, according to Jack's (1991) Silencing the Self model, related to depression in women. The scale

consists of 31 items rated from "strongly disagree" to "strongly agree". Of these items, five are reverse scored (items 1, 8, 11, 15, 21). The total scale scores range from 31 to 155 with higher scores indicating greater self-silencing. The STSS scale consists of four theoretically derived subscales: Externalized Self-Perception, Care as Self-Sacrifice, Silencing the Self, and Divided Self. The first scale, Externalized Self-Perception measures the negative external standards used to judge the self. The second and third scales, Care as Self-Sacrifice and Silencing the Self, both measure cognitions that influence the behaviours that women use to secure relationships, such as putting one's own needs second and inhibiting one's voice. Lastly, Divided Self measures the extent of the conflict between the persona that the women present outwardly and their sense of inner self and that creates internalized hostility and anger (Jack & Dill, 1992).

The original research on the STSS by Jack and Dill (1992) found the scale to have excellent psychometric properties. Face validity for the items is high, as all questions were derived from themes that were repeated by many of the women in the original interviews done by Jack. The internal consistency of the total STSS, tested using Cronbach's alpha, was excellent for all groups and ranged from .86 to .94. The individual subscales also demonstrated adequate internal consistency ranging from .60 to .90. However, the Care as Self-Sacrifice subscale had the lowest alphas (from .60 to .81) and the authors noted that caution should be taken if the subscale were to be used separately on its own. The test-retest reliability for the total scale was also excellent, ranging from $r = .88$ to .93. The STSS also demonstrated good construct validity as it correlated well with the BDI (Beck et al., 1961). In addition, when compared across three groups of women, scores on the STSS varied in severity according to the social contexts of the women. Women in the highest conflict group (those at the battered women's shelter) had the highest scores, those in the lowest conflict group (university students)

obtained the lowest scores, and the intermediate group (substance-abusing new mothers) fell between the other two groups in terms of scores (Jack & Dill, 1992).

Further research has also supported the validity and reliability of the STSS. Carr et al. (1996) reported reliability estimates with alphas ranging from .85 to and .89 and significant correlation between the STSS and the BDI (r = .49). For the individual subscales, Duarte and Thompson (1999) found reliability ranging from .70 to .86. However, recent study by Remen et al. (2002) found the subscales to have lower reliability ranging from .51 (for Divided Self) to .75 (for Silencing the Self). Nonetheless, both studies reported excellent reliability for the total scale .89 and .81, respectively (Duarte & Thompson, 1999; Remen et al., 2002).

Following various factor analytic studies of the STSS, some authors suggested removing a few items from the scale because of their poor loadings on the subscales. In their original study, Jack and Dill (1992) footnoted the suggestion that item # 1 and # 11 may need to be eliminated from the STSS. Shortly after, Stevens and Galvin (1995) suggested removing item #11 as it did not load on any factor in their study. Similarly, Duarte and Thompson (1999) suggested removing items # 1 and # 11.

For the present study, the original 31-item STSS was administered to participants but items #1 and #11 were excluded when calculating the full STSS score. The full score was used to determine the degree of self-silencing and to classify participants into either the high or low self-silencing group (see Sample Description section for more detail).

The Social Supportive Behaviors Scale – modified (SSB-M; Vaux, Riedel, & Stewart, 1987; see Appendix H, Section D)

The SSB was originally developed by Vaux and colleagues (1987) as part of a series of scales that measure different constructs of social support, including structure and function of

social networks, subjective appraisals of perceived support and supportive behaviours. The goal of the SSB was to be "a measure of five distinct modes of available supportive behavior" (Vaux et al., 1987, p. 213) that reflect emotional support, socializing, practical assistance, financial assistance and advice/guidance. The SSB has 45 items, each assessing one of the five modes of supportive behaviour thereby yielding five subscales. As an example, item #2 that taps into the socializing mode reads as "would visit with me, or invite me over" (Vaux, et al., 1987, p.233). Participants are asked to consider the likelihood that (a) a member of their family would provide such support and (b) a friend would provide such support by rating a Likert response scale with possible scores that range from 1 (no one would do this) to 5 (most family/friends would certainly do this). The score for a particular mode subscale is reflected by its average score that is calculated by the sum of scores that load on that subscale divided by the number of items. A higher score is indicative of more support in that area.

Vaux and colleagues (1987) conducted a number of tests on the psychometric properties of the SSB and found it to have good reliability and validity. To test the content validity of the SSB the 45 items were classified by three different groups of judges, composed of psychology faculty, graduate students and undergraduate students, into the five content categories (emotional support, socializing, practical assistance, financial assistance and advice/guidance). Most of the items were correctly classified by the judges and therefore changes were made to the classification of the items on the five subscales. The SSB was also found to have a moderate correlation with the Inventory of Socially Supportive Behaviours (ISSB; Barrera et al., 1981). The ISSB is a multi-item scale that examines the conditional occurrence of six different modes of support following stressful situations. Despite their similarity, the SSB and ISSB have some conceptual differences that are reviewed in Vaux et al. (1987). There are also some differences

as evidenced by the low to moderate correlations between the two scales. Even when controlling for total scores on the SSB, the partial correlation coefficients though significant remained low on theoretically related subscales. For example, Tangible Assistance on the ISSB and Practical Assistance on the SSB only had a correlation of r =.17 and Positive Social Interaction on the ISSB and Socializing on the SSB only had a correlation of r = .21. Correlations were higher for subscales that had more direct overlap between the two measures, such as Directive Guidance on the ISSB and Advice/Guidance on the SSB (r = .42). The SSB also demonstrated excellent internal consistency for each of the five subscales, with alphas ranging from .82 to .90. Finally, confirmatory factor analysis of the SSB found that all but one item loaded significantly onto the correct scales and of the significant items most loaded at > .70. Thus, as the authors conclude, these results "provided very strong evidence for the correspondence of the specific SSB items to the theoretical modes of support each was intended to operationalize" (Vaux et al., 1987, p. 227).

Although the SSB offers an assessment of the amount of five types of support received from family and friends, only emotional support and practical assistance were of interest in the present study. The original SSB was also slightly modified for the purpose of the present study by including intimate partner as an additional source of support (see Section D, Part 1). There is some precedence in the literature that supports the expansion of the SSB to include other specific network members. In a study on social support and substance abuse among homeless veterans, Benda (2006) expanded the SSB to include two additional sections inquiring about support from one's church and from other acquaintances. Likewise, Kennedy, and Bennett (2006), in a study on adolescent mothers and violence, modified the SSB to include male partners in order to examine the specific supports intimate partners provide to the young women. Thus, it seems appropriate to modify the SSB in order to obtain additional information about the support

behaviours of other specific network members, such as an intimate partner. For the current study, Section D Part 1 of the SSB was used to measure the amount of emotional support and the amount of practical support from intimate partners, from family, and from friends. The scores for family and friends were averaged together for each item to create a combined score for "other" sources of support.

Additionally, to measure the degree of satisfaction with emotional and practical support received from intimate partner and others (family and friends), an additional section (see Section D, Part 2) was developed at the end of the SSB. For each type of support, participants rated their satisfaction with the support received from family, friends, and intimate partner by using a six-point Likert response scale that ranged from 1 (very dissatisfied) to 6 (very satisfied). The response scale was based on the satisfaction scale from the Social Support Questionnaire (SSQ; Sarason, Levine, Basham, & Sarason, 1983). Once again the "other" score was obtained after by averaging together the item rating for family and for friends.

Quality Marriage Index (QMI; Norton, 1983; see Appendix H, Second E)

The QMI is a short self-report measure of relationship satisfaction. It consists of six interrelated items pertaining to the individuals' satisfaction with the quality of their intimate relationship. The first five items ask the respondents to rate their agreement to five statements about the quality of their relationship, on a 7-point Likert scale. For an example, one item reads "we have a good marriage" (Norton, 1983, p. 147). This subscale (Q-QMI), containing the first five items, is given a score by averaging the five items to get a mean score. The final sixth item asks the respondents to rate the degree of happiness in their marriage from "very unhappy" to "perfectly happy" using a 10 point scale (Norton, 1983, p. 146). This item acts as its own subscale (H-QMI) and the rating given is used as the score.

Subsequent psychometric research on the QMI finds the scale to have good validity and reliability. Heyman, Sayers and Bellack (1994) found the QMI to have good internal consistency reliability with a coefficient alpha of .97. As well, the authors found the QMI to correlate strongly with other measures of relationship satisfaction and adjustment including the Dyadic Adjustment Scale (DAS; Spanier, 1976) (r = .84 for women) and the Relationship Satisfaction Questionnaire (RSAT; Burns &. Sayers, 1992) (r = .87 for women). Likewise, Baxter and Bullis (1986) also found that the QMI had good internal consistency reliability with a Cronbach's alpha of .88. They also found the QMI to correlate well with other relationship variables including an r = .80 correlation to relationship commitment.

For the current study the QMI was used to assess the participants' general level of satisfaction with their intimate relationships with higher scores indicating great satisfaction. The scale was used to test the convergent validity of the STSS through the correlation of both scales. Convergent validity would be indicated by a positive correlation such that higher self-silencing would be associated with greater relationship dissatisfaction in women, as proposed in Jack's theory.

PROCEDURE

Quantitative Procedure for the Research Questionnaire

Individuals who responded to recruitment efforts were asked to complete either a hard copy or the online copy of the Research Questionnaire. Prior to completing the questionnaire, relevant information (see below) was given so that the participants would engage in the study on a voluntary and informed basis.

Blank hard copies of the questionnaire were made available for pick-up in the mail room of the Psychology Department or provided to participants upon request. Upon completion, these

hard copies could be mailed back to the researcher or dropped off in person at the secure drop-off point at Lakehead University.

Online copies of the Research Questionnaire were made available to participants through the webpage at *http://psychologystudy07.googlepages.com* that was linked to the questionnaire via a service called Survey Monkey (*www.surveymonkey.com*). Survey Monkey allows individuals to create surveys and collect responses confidentially and anonymously. Participants' responses were collected through the secure server but their IP addresses were not saved to preserve anonymity. The participants' responses to the survey and their personal information were stored in separate files on Survey Monkey and could not be connected to each other in any way. Survey Monkey utilizes numerous security measures, including physical, network, hardware and software safeguards to protect information. As well, the service uses SSL encryption in the transmission of data, which is used by online banks, and is in compliance with the American Health Insurance Portability and Accountability Act of 1996 (HIPAA). When the subscription to Survey Monkey is terminated, the electronic data will be deleted and permanently eliminated after thirty days. The termination of the subscription to Survey Monkey is targeted for July 2009.

For the present study, all the responses collected in the research questionnaire from participants were kept confidential. However, the identity of the participants was known only to the researchers through a unique five digit personal code created by the participants themselves. This personal code was used to identify individuals for Part 2 of the study so that they could be invited to the focus group discussions. The code appeared on the electronic research questionnaire and again on a separate electronic file containing the name and contact information of the participant. This allowed the researchers to preserve the anonymity of the participants

while enabling the cross-referencing between the two files if necessary for Part 2 of the study. Participants also had the option of not creating a personal code and not giving out identifying information if they decide against being involved in Part 2 of the study.

For the hard copy of the Research Questionnaire, participants were asked to create their own five digit personal code on the Consent Form and to copy that code onto their Research Questionnaire. Upon receipt of the completed hard copy of the Research Questionnaire, the consent form was separated from the questionnaire thus preserving the anonymity of the respondent. In order to identify willing participants for Part 2 of the study, the questionnaire was cross-referenced through the personal code back to the consent form that contained identifying information. As previously mentioned, participants had the option of not creating a personal code and not giving out identifying information if they decide against being involved in Part 2 of the study.

For both online and paper copies of the questionnaire, participants were provided with a Part 1 Cover Letter which gave more information about the study (see Appendix I) including the objectives and procedure of the study, the two stages (Parts 1 and 2) of the study, the voluntary nature of the individuals' participation, confidentiality and secure storage of the data, risk and benefits of participation, and the opportunity to receive a copy of the summary of results upon completion of the study. They were also informed that they would be entered into three $50 random prize draws for completing the Research Questionnaire, and two $25 random prize draws for participating in Part 2 of the study consisting of audio-taped focus group discussions. After reading the recruitment cover letter, the individuals were asked to sign a Part 1 Consent Form (see Appendix J). There was a space on the consent form where participants could indicate

whether or not they would like to be considered for Part 2 of the study, which consisted of audio-taped focus groups.

Following the completion of the questionnaire each participant was provided with a debriefing page for the study and with information on relevant support resources (see Appendix K). Those individuals who completed the paper copy were asked to return it to the researcher within one week. Shortly after the completion of Part 1 all participants who were not interested in Part 2 were sent a follow up thank you note, either by traditional mail or email (Appendix L).

Qualitative Procedure for Focus Groups

A subset of individuals who met the study criteria and volunteered for the second part of the study were invited to partake in a small focus group. An invitation to the focus group meetings was made by phone (see Appendix M) or email (see Appendix N). The women were provided with further information on the second part of the study to see if they were still interested in participating. In order to protect the methodological integrity of the study, the women were not informed as to which group they were in, or that they had been selected according to their scores on the STSS. Rather, they were informed that women with a range of scores on the assessment measures during Part 1 of the study had been invited to participate in Part 2 for a discussion about their thoughts and views on relationships and social support. Those who remained interested were scheduled for continuing in the study. Those who indicated an interest in participating in Part 2 but were not selected were sent a thank you letter by email (see Appendix O).

Each focus group ran from 60 to 90 minutes, followed a semi-structured format and was facilitated by J. Johnson. The focus groups took place at the Lakehead University campus on three separate evenings in the fall of 2008. Upon arrival to the focus group session, each

participant was given a Part 2 Cover Letter to read (see Appendix P). This letter explained the general purpose of the groups, the format and procedure of the discussion, which includes audio-taping of the session to allow transcription of the discussion later for data analyses and guidelines for the strong need among group members to respect each other's confidentiality. The women also signed a Part 2 Consent Form (see Appendix Q).

Following the signing of the consent forms, the women were asked to sit around a table. The facilitator then introduced herself and welcomed and thanked the women for participating. The facilitator also reminded the women about respecting each other's confidentiality and opinions. The audio-recorder was then switched on and the session started with the women introducing themselves by their first names only and saying a few words about their hobby in order to obtain a sample of their voice. The facilitator then proceeded to pose a number of questions to the women in order to generate conversation. The questions that were used to guide the discussions focused on self-silencing and social support (see Appendix R). However, the direction of the conversations was guided by the insights of the women. The conversation was allowed to go into related areas that the women felt were important, but the facilitator monitored the conversation to keep things on topic. After the session was over, the audio-recorder was turned off and the facilitator stayed behind to address any questions the women might have had about the resource sheet that was attached to the cover letter. If the women had further questions about self-silencing, social support, or depression and the implications of these variables they were directed on the resource sheet to contact either Jessica Johnson or Dr. Josephine Tan who would be able to provide more information (see Appendix K).

Following the completion of the focus groups discussions, the audio-recordings were transcribed verbatim for analysis. Unbeknownst to the facilitator at the time, an unfortunate

malfunction with the equipment had occurred during taping of the second half of the final focus group, which resulted in the loss of data. Nevertheless, the audio that did remain was transcribed and used in the analysis. The recordings from the first two groups, which were complete, were also transcribed.

Sample Description

Recruitment Sample

The majority of participants (n =213) completed the questionnaire online with only three filling in hard copies of the questionnaire. However, in 16 of the online cases the potential participant did not complete any part of the questionnaire proper after completing the electronic consent form. This may have happened for a number of reasons relating to the design of the survey website itself. If a participant were to close the internet browser after clicking the "accept button" following the consent form, she would automatically be exited from the survey and would have to start the process from the beginning with a new consent form. However, because IP addresses were not collected for privacy reasons there is no way to confirm this. After discounting the 16 online cases that did not fill out any part of the questionnaire, the final recruitment sample consisted of 200 participants (197 online participants plus 3 hard copy questionnaire participants).

Study Sample

The data on the 200 recruitment participants were first reviewed to determine if the individuals met the study criteria. A total of 82 participants were excluded from the statistical analyses for the following reasons:

(i) They had been in their current relationship for less than 12 months old (n = 2);

(ii) failure to provide information on the status of the relationship which made it impossible to ascertain whether or not they met the study criteria (n = 2);

(iii) significant amount of missing data on the STSS (n = 65). This was due in part to a problem early on in the data collection where it seems that only half of the STSS items were made available to participants of the online survey. This was ratified and participants thereafter had access to the full set of STSS items and

(iv) missing significant portions of the SSB (n = 13). This may be related to the large number of items on this scale, which seems to have caused some participants to skip over many of the items on the SSB and straight to the end of the survey.

After the exclusion of the 82 participants as mentioned above, a total of 118 were retained for statistical analyses. Although three of them failed to give their age, it was possible to determine that their age was greater than 18 based on their highest level of education. Hence they were considered to have met the study criteria.

The STSS scores of the final sample (N = 118) ranged from a low of 34 to a high of 116. The original intent was to divide the final sample into equal thirds based on their STSS scores to derive a high, medium, and low self-silencing group. However, it was necessary to adjust the cut-off scores in order to obtain six women from the high group and five women from the low group who would agree to come in for the focus group discussion, while at the same time maintaining a middle group to separate the high and low group. As a consequence of the adjustment to the cut-off scores, the range of STSS scores for the high group (n = 41) was 73 to 116, and the range for the low group (n = 70) was 34 to 67. The middle group (n = 7) with STSS scores of 68 to 72 were excluded from all analyses. For the purpose of Part 1 (quantitative) of

the study, the participants hence consisted of 111 women of whom 41 were classified into the high group and 70 into the low group.

The demographic information for the Part 1 participants was examined and is summarised in Table 1. The age range of participants for both groups was 19 to 44, with the average age in the high self-silencing group being 29.63 years (SD = 7.37) and the average age in the low self-silencing group being 28.49 (SD = 5.76). A t-test showed that there was no significant difference in the average age between the two groups t (108) = -.904, *n.s.* As for relationship status, most of the women in the high self-silencing group (46.3%) and in the low self-silencing group (54.3%) indicated they were married. On average the women in the high group had been in their current relationship for 77.88 months (SD = 69.15) and the women in the low group had been in their current relationship for an average of 66.87 months (SD = 48.45) with no significant difference between the two groups t (108) = -.996, *n.s.* The majority of participants in both the high self-silencing (72.5%) and low self-silencing (79.7%) groups did not have children at the time of the study. In terms of ethnicity most of the women in the high self-silencing group identified themselves as White (85.4%), as did most of the women in the low group (87.1%). Most of the women in both groups had an undergraduate university or post graduate education (high = 62.5% and low = 82.3%)

Focus Group Sample

Participants for Part 2 (qualitative) of the study were recruited from a subsample of the participants from Part 1 (quantitative). To be considered for the focus groups the participants had to be living in the Thunder Bay area, had to have participated in Part 1 and , volunteered to be contacted for Part 2, and must have given their five digit code and contact information. From the study sample of 118 women, 88 were excluded from Part 2 as they did not reside in the

Thunder Bay area. Another 6 participants were excluded, as they did not give a personal code. This resulted in a list of 24 potential participants for the focus groups; all 24 incidentally were classified as either high or low self-silencing in Part 1 of the study and were invited to participate in separate high and low self-silencing focus group meetings (see pages 60 and 61).

Out of the 24 who were invited; only a total of six women actually made it to the meetings. The low self-silencing focus groups (n = 4, STSS range 37-66) were conducted in two separate session with two women in each. The high self-silencing focus group was carried out in a single session (n = 2, STSS scores 95 and 96).

A summary of the demographic information of the six women who participated in the focus groups is provided in Table 2. The difference in mean age of participants for the high self-silencing group (M = 34.50, SD = 13.44) was not significantly different from for the low self-silencing group (M = 31.25, SD = 8.66), $t(4)$ = -.37, *n.s.* Likewise, the mean difference in the duration of current relationship was not significantly different for the high self-silencing group (M =54.00, SD = 33.03) compared to the low self-silencing group (M = 129.00, SD = 156.98), $t(4)$ = -1.04, *n.s.* Most of the women in both the high and the low self-silencing groups were married, had no children, identified themselves as "White" in their ethnicity, had post-graduate education and were either employed or studying (with part time employment) at the time of the study.

RESULTS

Overview of the Research Design

The current study had two main objectives. The first, which used quantitative methods, explored the possible moderating effect of social support on the relationship between self-silencing and depression in women. The second objective was to obtain narrative information

through focus groups to contextualize the quantitative information and to find out why women self-silence and the role that social support plays in their self-silencing.

Quantitative Analysis

Study Revisited

The purpose of the first part of the study was to examine social support (emotional and practical) from different sources (partner, others) as a possible moderator between self-silencing and depression. Emotional support involves elements such as receiving comfort and encouragement from others or the feeling that one is being understood. Practical support focuses on more interactive elements such as having others providing loans (car, money) in times of need and help with different daily tasks such as childcare. These two modes of support (emotional and practical) were looked at in terms of the amount of perceived support and one's overall satisfaction with the support received. The women in the study were asked to consider these elements of support received from their intimate partner and from others (i.e., family and friends).

Quantitative Analytic Strategy

To analyze the quantitative data, both MANOVA and hierarchical multiple regression were used. The MANOVA was employed to assess for group differences on the variables relating to social support variables. Specifically, four separate MANOVAs as a function of group (high and low self-silencing) were run on (a) the amount of emotional support received from the partner and from others, (b) the amount of practical support received from the partner and from others, (c) the degree of satisfaction with the emotional support received from the partner and from others, and (d) the degree of satisfaction with the practical support received from the partner and from others.

Hierarchical multiple regressions was used to address the research question about the role of the social support variables as a moderator between self-silencing and depression. To this end, four separate hierarchical multiple regressions as shown below were run on the depression criterion (HAM-D) in which the predictor (STSS Group) and the moderator (social support variables) were entered first, followed by all the product terms between STSS and the moderator variables:

a. STSS, amount of emotional support received from partner (EA-partner), amount of emotional support received from others (EA-others), STSS x EA-partner, STSS x EA-others.

b. STSS, amount of practical support received from partner (PA-partner), amount of practical support received from others (PA-others), STSS x PA-partner, STSS x PA-others.

c. STSS, satisfaction with emotional support received from partner (ES-partner), satisfaction with emotional support received from others (ES-others), STSS x ES-partner, STSS x ES-others.

d. STSS, satisfaction with practical support received from partner (PS-partner), satisfaction with practical support received from others (PS-others), STSS x PS-partner, STSS x PS-others.

Given that the moderator variables were continuous in nature, they were standardized for the multiple regression to reduce the likelihood of multicollinearity among the variable that were entered into the regression equation (Cohen, Cohen, West & Aiken, 2003) and to ease the interpretation of the moderator effects (Frazier, Tox, & Barron, 2004).

Pre-Analysis Issues

Missing Data and Number of Cases

Prior to analysis, the final data set was first screened for accuracy and missing items with the use of the Statistical Package for the Social Sciences (SPSS). One of the benefits of using Survey Monkey to administer the questionnaire is the ability to electronically download the data file, which eliminates most of the manual data entry and minimizes human error when imputing the data. Nevertheless, the data was still thoroughly inspected and each variable was examined to ensure that scores for each variable were within range (Tabachnick & Fidell, 2007).

For participants who were missing a small number of items (less than 5%) on one or more scales or subscales, a mean substitution was used for these missing items, wherein the missing item is substituted with the mean value of the item for the total sample (Tabachnick & Fidell, 2007, p. 67). Two participants did not respond to a small number of items from the HAM-D (less than 5%) and so the item mean score for the full sample was inserted for the missing values. For the STSS, 10 participants were missing up to 5% of the items for the full scale and so the item mean score for the full sample was inserted for these missing items. As well, 29 participants were missing a minimal amount of items from the SSB by subscale and source. For these items the item mean was once again substituted for each of the missing items. Lastly, one individual was missing a single item on the QMI and so the sample mean for this item was inserted for the missing variable.

Another preliminary issue with the data relates to ensuring a sufficient number of cases to adequately support the multiple regressions. One way of estimating this is through the use of the following equation: $N \geq 50 + 8m$ with N being roughly the number of cases needed and m being the number of independent variables. For this study there were 9 predictor variables and 1

criterion which equates into needing approximately 122 subjects. The sample size for this study was 117, which is slightly fewer than recommended.

Univariate and Multivariate Outliers

The data set was also screened for the presence of univariate and multivariate outliers that can affect the results (Tabachnick & Fidell, 2007). To test for univariate outliers, each of the scale score variables was standardized into *z* scores using SPSS. Any case with a *z* score greater than ± 3.29 ($\pm$ 3 standard deviations) was considered a univariate outlier. In the current data set, there were a small number of cases where some of the variables came up as significant outliers. However, it was decided to hold off on transforming or deleting these cases until the presence of multivariate outlier was explored. Although transforming variables with univariate outliers can increase the normality of the distribution of the variable it can also reduce generalizability, particularly if the cases are extreme but legitimate scores or when the range of scores is restricted. Thus the decision was made to screen for multivariate outliers, which can detect combinations of score variables that are extreme or unusual, in order to establish whether the univariate outliers were also significant multivariate outliers before performing any transformation or case deletions. The detection of multivariate outliers was done by examining the Mahalanobis distance and the Cook's distance. According to Tabachnick and Fidell (2007) the Mahalanobis distance describes the how far, or how "outlying", a particular case is away from the centroid, or central point created by the clustering of the remaining cases. However, even though a case has a significant Mahalanobis distance it will not necessarily have a significant influence on the regression coefficient and so it would be useful to also look at Cook's distance that examines the potential influence of each outlier (Stevens, 1986). The results for this data set indicate that a small number of cases had significant Mahalanobis

distances; however they did not have significant Cook's distances (< 1) and were not considered to be influential outliers. Hence, they were not altered.

Normality, Linearity and Homoscedasticity

Assumptions of normality, linearity and homoscedasticity were assessed by examining the residuals scatterplots, created through the regression analysis, which examine the distribution of the residuals in relation to the predicted dependent variables scores (Tabachnick & Fidell, 2007, p. 125). Examination of the scatterplots revealed some mild violation of normality among the variables. For example, the scatterplot for the analysis of amount of emotional support from partner and others revealed a clumping of variables below zero and a scatter for those points above zero, indicating some skewness of the residuals. However, because the violations were mild, and scatterplots revealed linearity among the residuals with only mild deviations from homoscedasticity (Tabachnick & Fidell, 2007), the variables were not transformed in order avoid the unnecessary complexity of interpreting results that have been subject to transformations. The regression scatterplots can be viewed in Figure 1.

Multicollinearity

To test for multicollinearity a bivariate correlation analysis using the pooled sample was run on the various variables (see Table 3). Multicollinearity occurs when two or more predictor variables are highly correlated which can be problematic for interpretation as it can lead to unreliable estimations of the regression coefficient (Cohen, Cohen, West, & Aiken, 2003). None of the combinations of variables reached the .90 or greater cut-off that would suggest possible multicollinearity as defined by Tabachnick and Fidell (2007). As well, the collinearity statistics from the regression, including the variance inflection factor (VIF) and the tolerance values, were examined for potential multicollinearity among the variables. It is generally accepted that a VIF

of 10 or greater or a tolerance of .10 or less is indicative of serious multicollinearity among the variables (Cohen, Cohen, West, & Aiken, 2003). None of the regression terms displayed VIF scores or tolerances above the suggested cut-offs. Thus there appears to be no problem with multicollinearity in the current study.

Quantitative Findings

Correlations Among The Variables

Correlations with STSS

As predicted by Jack's theory (1991), STSS scores and depression scores, as measured by the HAM-D, were positively correlated ($r = .43$, $p < .001$). That is, the higher one's STSS score the higher her depression score. In contrast, ratings of overall marital happiness were negatively correlated to STSS scores ($r = -.50$, $p < .001$), as were ratings of marital quality ($r = -.47$, $p < .001$). That is, greater marital happiness and quality were associated with lower amounts of self-silencing. The amount of emotional and practical support received from various sources was also negatively correlated to STSS scores. For example, a higher amount of emotional support from one's partner was correlated with lower STSS scores ($r = -.49$, $p < .001$). A similar negative correlation was observed between STSS scores and amount of emotional support from others ($r = -.40$, $p < .001$). The amount of practical support from different sources was also negatively correlated to STSS scores, but to a lesser degree for both partner ($r = -.27$, $p < .01$), and others ($r = -.25$, $p < .01$). Similar negative correlations were seen between STSS scores and satisfaction with support from various sources. Ratings of satisfaction with emotional support from partner ($r = -.56$, $p < .001$) and others ($r = -.42$, $p < .001$) had a strong negatively correlation with STSS scores. Likewise, satisfaction with practical support negatively correlated to STSS scores for both partner ($r = -.28$, $p < .01$) and others ($r = -.26$, $p <. 01$) but the

relationship was not as strong as for emotional support. A summary of the correlations for all the variables can be found in Table 4.

Correlations with HAM-D

The current analysis found that depression scores, as measured by the HAM-D, negatively correlated with happiness in one's relationship ($r = -.43, p < .001$) and with the self-rated quality of one's relationship ($r = -.35, p < .001$). Additionally, the HAM-D also had a strong negative correlation with satisfaction with emotional support from partner ($r = -.33, p < .001$). Satisfaction with practical support from partner also negatively correlated with HAM-D scores but to a lesser degree ($r = -.27, p < .01$). Likewise, the amount of emotional support from partner ($r = -.24, p < .05$) and the amount of practical support from partner ($r = -.28, p < .01$) also negatively correlated with depression scores. Interestingly, not all measures of support from other sources were significantly associated with the HAM-D. While both the amount of emotional support from others ($r = -.26, p < .01$) and the satisfaction with emotional support from others($r = -.25, p < .01$) were correlated with depression scores, neither amount nor satisfaction with practical support from others were correlated with the HAM-D.

Correlations Among the Social Support Variables

The amount of support from a source was positively correlated with degree of satisfaction with the support from that source. For example, higher amount of emotional support from partner was correlated with higher satisfaction with emotional support received from partner ($r = .78, p < .001$). The same was observed for the correlations between amount and satisfaction of practical support received from partner ($r = .70, p < .001$), correlations between amount and satisfaction of emotional support from other ($r = .73, p < .001$), and correlations between amount and satisfaction with practical support from others ($r = .60, p < .001$). Furthermore, the amount

of practical support and of emotional support from a particular source was positively correlated. For partner source, the correlation was .74, $p < .001$, and for the other source, the correlation was .78, $p < .001$. The same was seen for the satisfaction of practical and emotional support from a particular source with partner ($r = .63$, $p < .001$) and others ($r = .52$, $p < .001$)

Group Differences

Differences on the STSS. Independent-sample *t*-tests were conducted to test whether or not the women in the high self-silencing group differed significantly in their level of self-silencing from the women in the low self-silencing group. The test for STSS scores was significant, $t(109) = 18.74$, $p < .001$, as would be hoped for based on the study design. The women in the high self-silencing group ($M = 88.39$, $SD = 10.87$) reported engaging in significantly higher amount of self-silencing on the STSS then the women in the low self-silencing group ($M = 53.84$, $SD = 8.38$).

Differences on the HAM-D. Group differences on depression scores were also explored. A *t*-test on the HAM-D was significant, $t(60.45) = 3.60$, $p = .001$, indicating there was a difference in the level of depression between the two groups. Women in the high self-silencing group ($M = 31.95$, $SD = 10.75$) on average had higher depression scores then women in the low self-silencing group ($M = 25.19$, $SD = 7.05$).

Differences on the QMI. Differences between high and low self-silencing women on their ratings of satisfaction with their intimate relationship were explored. The level of satisfaction with the quality of the relationship (Q-QMI) and the overall rating of happiness (H-QMI) one experiences within that relationship were examined. A *t*-test on the Q-QMI was significant, $t(109) = 4.55$, $p < .001$, indicating there was a difference in the rating of the quality of the intimate relationship between the two groups. Generally, women in the high self-silencing

group (M = 5.28, SD = 1.23) rated the quality of their relationship less favourably than the women in the low self-silencing group (M = 6.31, SD = 1.09). Likewise, a t-test on the H-QMI was significant, $t(109) = 3.84$, $p < .001$, indicating a significant difference in ratings of overall relationship happiness. Women in the high self-silencing group (M = 7.05, SD = 2.06) on average had lower ratings of happiness then women in the low self-silencing group (M = 8.40, SD = 1.18).

Differences in the amount of emotional support. A MANOVA was carried out on the amount of emotional support from the partner, and amount of emotional support from others. The analysis revealed that the test for Box's M was significant at $p < .001$, indicating a violation of the assumption of homogeneity of variance covariance matrices. As a result, Pillai's Trace, which is a more robust criterion than the other multivariate criteria to unequal sample sizes and violation of the homogeneity assumption, was used to evaluate the omnibus multivariate effects (Tabachick & Fidell, 2007).

The results showed a significant omnibus Group effect, $F(2, 108) = 20.16$, $p < 001$, $\eta^2 = .27$, power > .99. Univariate F-tests with the Bonferroni correction showed significant Group differences on both variables. Both amount of emotional support from the partner, $F(1, 109) = 29.26$, $p < .001$, $\eta^2 = .21$, power > .99, and amount of emotional support from others, $F(1, 109) = 25.23$, $p < .001$, $\eta^2 = .19$, power > .99, discriminated the two groups. Means comparisons revealed that the low self-silencing group reported receiving greater amounts of emotional support from the partner (M = 4.74, SD = .35) and from others (M = 4.33, SD = .47) than did the high self silencing group (partner, M = 4.10, SD = .87, other, M = 3.81, SD = .62). The within-group descriptive statistics on the amount of support variables can be found in Table 5.

Differences in the amount of practical support. A MANOVA was also used to examine the two variables for amount of practical support from partner and amount of practical support from others. The SPSS outcome revealed unequal sample sizes and a significant test for Box's M at $p < .001$ and as a result, Pillai's Trace, which is a more robust criterion, was used to evaluate the outcomes.

The results showed a significant omnibus Group effect, $F(2, 108) = 5.23$, $p < 01$, $\eta^2 = .09$, power = .83. Univariate F-tests with the Bonferroni correction showed significant Group differences on both variables. Both amount of practical support from the partner, $F(1, 109) = 7.76$, $p < .01$, $\eta^2 = .07$, power = .79, and amount of practical support from others, $F(1, 109) = 7.37$, $p < .01$, $\eta^2 = .06$, power = .77, discriminated the two groups. Means comparisons revealed that the low self-silencing group reported receiving greater amounts of practical support from the partner ($M = 4.74$, $SD = .40$) and from others ($M = 4.27$, $SD = .53$) than did the high self silencing group (partner, $M = 4.45$, $SD = .69$, other, $M = 3.96$, $SD = .65$). The within-group descriptive statistics on the amount of support variables can be found in Table 5.

Differences in the level of satisfaction with emotional support. In order to test group differences relating to satisfaction with support a MANOVA was carried out on the two satisfaction with emotional support variables, namely the satisfaction with emotional support from the partner and from others. The SPSS outcome revealed unequal sample sizes and a significant test for Box's M at $p < .001$ and as a result, Pillai's Trace, which is a more robust criterion, was used to evaluate the outcomes.

As with the amount of support, the results for satisfaction with emotional support showed a significant omnibus Group effect, $F(2, 108) = 22.23$, $p < 001$, $\eta^2 = .29$, power > .99. Univariate F-tests with the Bonferroni correction showed significant Group differences on both variables.

Both satisfaction with emotional support from the partner, $F(1, 109) = 30.80$, $p < .001$, $\eta^2 = .22$, power > .99, and satisfaction with emotional support from others, $F(1, 109) = 20.17$, $p < .001$, $\eta^2 = .16$, power > .99, discriminated the two groups. Means comparisons revealed that the low self-silencing group reported greater satisfaction with emotional support from the partner ($M = 5.61$, $SD = .60$) and from others ($M = 5.07$, $SD = .74$) than did the high self silencing group (partner, $M = 4.61$, $SD = 1.30$, other, $M = 4.32$, $SD = 1.02$). The within-group descriptive statistics on the amount of support variables can be found in Table 5.

Differences in the level of satisfaction with practical support. Lastly, a MANOVA was carried out on the two variables, which were satisfaction with practical support from the partner and from others. The SPSS outcome revealed unequal sample sizes and a significant test for Box's M at $p < .001$ and as a result, Pillai's Trace, which is a more robust criterion, was used to evaluate the outcomes.

The results showed a significant omnibus Group effect, $F(2, 108) = 5.38$, $p < 01$, $\eta^2 = .09$, power =. 83. Univariate F-tests with the Bonferroni correction showed significant Group differences on both variables. Both satisfaction with practical support from the partner, $F(1, 109) = 7.41$, $p < .01$, $\eta^2 = .06$, power = .77, and satisfaction with practical support from others, $F(1, 109) = 6.47$, $p < .05$, $\eta^2 = .06$, power = .71, discriminated the two groups. Means comparisons revealed that the low self-silencing group reported greater satisfaction with practical support from the partner ($M = 5.76$, $SD = .67$) and from others ($M = 5.40$, $SD = .65$) than did the high self silencing group (partner, $M = 5.22$, $SD = 1.41$, other, $M = 5.01$, $SD = .96$). The within-group descriptive statistics on the amount of support variables can be found in Table 5.

Regression Analyses

A hierarchical multiple regression (see Table 6 for summary) was conducted on HAM-D as the criterion variable with the predictor variables entered in the following order: STSS, amount of emotional support received from partner (EA-partner), amount of emotional support received from others (EA-others) at Step 1 and STSS x EA-partner, STSS x EA-others at Step 2. Results showed that at Step 1, there was a significant omnibus main effect [$\Delta R^2 = .14$, $\Delta F(3, 107) = 5.98$, $p < .001$] with STSS as the significant predictor ($\beta = .29$, $t = 2.72$, $p < .01$) No significant results were obtained at Step 2.

A hierarchical multiple regression (see Table 7 for summary) was conducted on HAM-D as the criterion variable with the predictor variables entered in the following order: STSS, amount of practical support received from partner (PA-partner), amount of practical support received from others (PA-others) at Step 1 and STSS x PA-partner, STSS x PA-others at Step 2. Results showed that at Step 1, there was a significant omnibus main effect [$\Delta R^2 = .16$, $\Delta F(3, 107) = 6.99$, $p < .001$]. There were two significant predictors, namely STSS ($\beta = .31$, $t = 3.35$, $p < .001$) and PA-partner ($\beta = -20$, $t = -1.99$, $p < .05$). No significant results were obtained at Step 2.

A hierarchical multiple regression (see Table 8 for summary) was conducted on HAM-D as the criterion variable with the predictor variables entered in the following order: STSS, satisfaction with emotional support received from partner (ES-partner), satisfaction with emotional support received from others (ES-others) at Step 1 and STSS x ES-partner, STSS x ES-others at Step 2. Results showed that at Step 1, there was a significant omnibus main effect [$\Delta R^2 = .17$, $\Delta F(3, 107) = 7.26$, $p < .001$] with STSS as the significant predictor ($\beta = .23$, $t = 2.19$, $p < .05$) No significant results were obtained at Step 2.

A hierarchical multiple regression (see Table 9 for summary) was conducted on HAM-D as the criterion variable with the predictor variables entered in the following order: STSS, satisfaction with practical support received from partner (PS-partner), satisfaction with practical support received from others (PS-others), STSS x PS-partner, STSS x PS-others at Step 2. Results showed that at Step 1, there was a significant omnibus main effect [$\Delta R^2 = .16$, $\Delta F(3, 107) = 6.86$, $p < .001$] with STSS as the significant predictor ($\beta = .31$, $t = 3.34$, $p < .001$) No significant results were obtained at Step 2.

Qualitative Analysis

The narratives generated from the focus groups were transcribed to accommodate qualitative analysis. All identifying information was removed in the transcribed data. The participants were given pseudonyms to protect their identities further. The transcribed data was analysed in part with the N-Vivo program. N-Vivo is a computerised qualitative analysis program designed to assist researchers in processing text based information. The program was used in the current study to help organize and dissect the data for analysis. N-Vivo was used by the researcher to sort and classify themes in the data through the use of "tagging" or the highlighting of important words and phrases. From these tags different themes and trends between participants and across groups can be formulated, reviewed and refined. For the current project themes related to the women's lived experiences of social support and self-silencing in and out of their intimate relationships were explored. The similarities and differences in the beliefs of women high or low in self-silencing were explored. Also, within the high and low self-silencers, the importance of emotional support and practical assistance received from different sources and how it influences the women's psychological status (depressive symptoms) was examined.

Qualitative Analytic Strategy

The narrative transcripts from the focus groups were analyzed using a process called thematic analysis. Thematic analysis was chosen for a number of reasons including its compatibility for use with small data sets and the flexibility it provides to the novice researcher for comparing and contrasting different groups (Attride-Sterling, 2001; Braun & Clarke, 2006). Thematic analysis has become an increasingly popular method in the literature, although, until recently it was not often explicitly defined or acknowledged as the main method of analysis (Boyatzis, 1998; Braun & Clarke, 2006; Dey, 1993).

Thematic analysis can be conceptualized as a set of intertwining steps which are fluid and reciprocal between one and the next (Braun & Clarke, 2006). The process starts with a period of familiarization with the data; often this involves the actual act of transcribing the data or thorough read-throughs if the textual data is preexisting. Next, one begins the process of "coding" which involves the breakdown of the textual data "into manageable and meaningful text segments, with the use of a coding framework" (Attride-Sterling, 2001, p. 390). The coding schemes can be devised a-priori based on previous work or literature reviews, and can be data-driven and arise out of the text itself or a combination of both can be used (Fereday & Muir-Cochrane, 2006). For the current analysis a combination of both theory-driven and data-driven codes were used. Based on the earlier literature review and the researchers' knowledge of the topic, there were some elements that would be expected to be the text and as a result some of the coding was decided a priori. However, attention was also given to recognizing different minor codes which developed out of patterns from within the data. Coding is a rigorous process where full and equal attention must be given to all parts of the data as it is the groundwork for the rest of an analysis. As coding proceeds it is likely that potential trends or themes will become

apparent which dovetails one into the next step of arranging and refining the codes into thematic categories. During this phase the initial codes are arranged into theme clusters which create a smaller number of organizing or sub-themes and then these are worked into main themes or categories (Attride-Sterling, 2001). As one develops various candidate themes it is important to continually review and revise these themes to ensure they fit the data. The actual excerpts of text that were coded should also be collated under each theme. Then, the themes and categories should be examined for internal homogeneity and external heterogeneity, considering each category and sub-theme in relation to each other and to the data set as a whole (Braun & Clarke, 2006). Finally, all the findings need to be summarized into a convincing and meaningful account that is accessible for others to consider (Dey, 1993).

As well it should be noted that, for the purpose of describing the information obtained from the focus groups, pseudonyms were assigned to the participants to protect their identities. Jane and Dorothy (pseudonyms) were from the high self-silencing groups while Kate, Jennifer, Eleanor and Sally (pseudonyms) were from the low self-silencing group. A brief description of their background is provided in Table 2.

Qualitative Findings

Category 1: Focus on Aspects of Self Silencing

Topic 1: Communication with Partner

The women in both the high and low self-silencing groups were asked if there were times when they might be reluctant to share their thoughts or feelings with someone important, such as their partner. They were also encouraged to talk about the reasons why, or times when, they were more or less likely to share their thoughts and feelings with their partners. Although both groups generally felt it was important to communicate with one's partner, they engaged in

varying degrees of self-silencing and differed in the reasons for not sharing their thoughts and feeling with their partners.

High self-silencing women. Both Jane and Dorothy readily agreed that there were times when they had been reluctant to share things with their partner, such as when they felt it would lead to arguments. For example, Jane said she finds she holds back on discussing things with her partner when she feels it may up-set him or lead to a fight. However, the issues would often come out later in more heated conversations later on. When this happens, she ends up being the one who feels hurt. As Jane explained:

> *I'm reluctant to describe my thoughts and feelings like, like if I think I'm going to hurt his feelings. Or ya, that's like really, like I do not want that conflict. Like I do not enjoy fighting with him. I do not enjoy getting into that and if there there's something that is going to, ya know, aggravate him or rock the boat I would rather just keep it to myself and then it'll eventually come out.*

Dorothy said she finds she puts off discussing her own issues when she feels there are too many other obligations or issues that need to be addressed first. There is a sense that by the time everyone else has been taken care of there is no time or energy left for her to discuss her feelings. Dorothy described her feelings like this:

> *Ah, I, we have a really busy life we have two teenage children [. . .] both work full time, and I have a dog as well (laughter) who takes up tons of my time. Uh, but I do find that I sort of hold back on discussing some of my feelings because there's so much, so many other things going on in our lives.*

As well, both women described how they avoided discussing the details of specific topics or areas of concern if they felt their partners lacked knowledge or interest in the subject. Instead, the women found they would gloss over details by just providing short and trivial summaries of the things that were occurring in some important areas of their lives. As Jane relates:

> *I think it's the same thing because, um, my boyfriend's four years older than me and he has his career established and so in some ways it's almost like we have*

> *our own little worlds and we don't really, like, I don't really talk to him about school. Like, I'll tell him what I'm studying or whatever, but I don't get into it if I have a difficult problem. He doesn't, ya know, I don't really let him know about that stuff.*

Interestingly, both the women felt their partners did the same kind of summarizing when talking about certain areas of their lives.

Additionally, the high self-silencing women tended to find it easier to connect and communicate with their partners when the topic is something they both have an interest in, such as their children. Nevertheless, these women still found it difficult to communicate with their partners as much or as regularly as they would like. So they put extra effort into finding times and places when they could feel comfortable enough to freely share with their partner their thoughts and feelings. For example, both women discussed having "date" nights with their partners. These evenings were seen as a chance for the women to spend time with their partners and to discuss things that are important to the relationship as Jane explained:

> *So like one day of the week we have this specific day and its, it's been really nice [. . .] I've found that it's made us closer because then that whole night is devoted to us and anything we have to talk about like we talk about that night.*

Low self-silencing women. In general, the four women, Kate, Jennifer, Eleanor and Sally, in the low self-silencing groups felt they communicated well in their relationship with their partner, even at times describing themselves as "very open"(Kate). Nevertheless, these women still described times when they engaged in self-silencing behaviours, although, for different reasons as compared to the high self-silencing women. One participant, Kate, explained that, even though she felt she could talk openly with her husband, she would censor certain things during their discussions if she felt that the information would make her husband feel differently about her or another person. As Kate described:

> *I would share everything for the most part. Although with some guard when it comes to things like talking about my sister because he doesn't like her already so ya know I have to be, kind of, I don't want to encourage him to dislike her anymore then he already does. [. . .] I mean just little details sometimes he'll ask for details of what's going on and I'll refrain from sharing the whole story I'll just give him a little points to the story. Just that he doesn't have to grab on to the little negativity parts.*

Some of the women also refrained from talking about certain things with their partner if they felt the issues were "unimportant" or something that would just pass with time, as Sally described:

> *With my partner I'm, I know there's little, the topics that you don't really talk about with him. [. . .] so I think that's probably, more the, I think probably just the little things that, unimportant things that are probably, I don't really talk about.*

Instead of talking about these "little things" some of the women would engage in distractions or just try and "let them go". Some of the women also reported that, even though they would try and talk about what was important to them, this often would come second to listening to what is important to their partner. If something was bothering their partner they would pay attention to his difficulties first as Kate recounted:

> *But um I guess if there was a time that I wouldn't share completely with my husband could potentially be um he works in the bush and he's got like um lots of anxiety about his job. So if I can, if I'm getting that he's feeling like his head is spinning then I'm probably not going to talk so much about stuff that's going on with me as so much as I'm going to allow him to just let it vent off.*

Interestingly, one participant in this group denied any self-silencing behaviours in her relationship with her partner and even denied ever "really" fighting with her partner. However, this same participant was very emphatic about having someone who would just listen to her "vent" and did not seem to care so much about the response. As she stated:

> *It's like I know he wouldn't respond to them (emails) because he was busy but I just kind of ah sense he'll read it, he'll read it, he'll read that. You know my form of kind of one sided communication I guess that he was reading it (Jennifer).*

Regardless of their actual engagement in silencing behaviours, most of the women in the low self-silencing group felt that they could communicate well with their partner and that their partner has a deep understanding of who they are. As a result many of the women felt they already shared enough with their partner, if not too much as Kate explained "I would think I share everything with him, probably more then I should."

Topic 2: Communication with Friends and Family

The women were also asked to discuss if there were times when they were reluctant to share thoughts and feelings with different friends and family members. They were encouraged to talk about different situations that impacted on whether or not they communicated their thoughts and feelings with others outside of their intimate relationship. Overall the women in this study valued having a friend or family member they could share their thoughts and feeling with when needed. However, there were also times and situations when the women self-silenced in these relationships. As within their intimate relationships, women from the high self-silencing group discussed censoring themselves for different reasons than the low self-silencing groups.

High self-silencing women. For the high self-silencing women, having friends and family they could talk to was important even when they were communicating well in their relationships. These other relationships provided the women with different opportunities to express themselves. Nevertheless, there were still times and situations when the high self-silencing women reported withholding their thoughts and feelings from family or friends. Both the women articulated the importance of deliberately choosing when and with who to share things with, as Dorothy

illustrates when she discussed being careful with who she talks to about her educational aspirations:

> *I think it depends upon the friends that you have. There are certain friends that I share certain things with so I talk about those things with them. Um, like the education thing, I'm really careful about, who I talk to about that. Because, ah a lot of people aren't as educated as I am, they're not. So there's no point.*

For these high self-silencing women it was not always easy to share personal thoughts and feeling with others, particularly when there was a fear that the other person would not understand. Therefore, these women found it easier to talk with friends and family when there was more common ground or interests. As Dorothy explained:

> *So I'm finding I'm tending to socialize more with the um, the sports group that my children are involved in [. . .] the mom's all get together, the parents and we have our meeting and we go for drinks after, yah know.*

Part of this selective behaviour appears to have risen out of a concern with being hurt or criticized for one's thoughts or choices by the other person. This affects current relationships and can even hamper the formation of new ones as Jane discussed:

> *So it really depends like I, and it depends on the person to. Like I know um, in their background, like one of the girls I work with now she's highly religious and I almost can't even talk to her that my boyfriend and I live together. Because it's almost, you know, like you sort of feel like someone is looking down on you. Like, wow, you're not married, and. It's just, you're like woo, like this is going back. And so that really affects, ya know, who you're going to be to be open with and what you're going to tell them.*

There was also concern that, at times, family would disagree or disapprove of some of the things the women had chosen to do with their lives. Although family was generally felt to be supportive, their opinion can have a strong impact and so, as Dorothy discussed, one learns to be careful with sharing too much with her mother:

> *So, she's proud that I am pursuing an education and a career but she really wants to know that meals are made and the kids are fine and the curtains match the couch, ya know. That's still the priority. So I have to be careful what I talk to her about. Like she's, oh ya know, you're never happy in your job if I'm looking for a promotion. Or if I'm looking for another opportunity, it's like well why can't you be happy with what you've got? So it's there are limits.*

Low self-silencing women. Most of the women in the low self-silencing group were very candid about censoring thoughts and feelings from their family and friends. As with the high self-silencing women, they were often careful in picking and choosing who to share with. However, there were different motivations for this selectiveness.

A number of the women said they would avoid discussing certain topics or voicing their concerns with others if they were worried that it could start a fight or damage the relationship. With some relationships, particularly with family, maintaining kinship in the long run was more important than expressing one's concerns in the interim. This dynamic was illuminated by Kate as she spoke of her relationship with her sister:

> *her behaviour as far as I'm concerned is less than stellar, she's being really selfish. So I wouldn't just come out and say that to her because I wouldn't to get in a big fight with her that would potentially end our relationship or have us stop communicating with each other because she lives out of town. So rather then tell her how I really feel about how she is behaving in this situation I just sort of nod and smile.*

Self-censoring was also use by the low self-silencing women as a means of avoiding conflict. At times, this self-censoring was used to keep the peace among various family members as Jennifer explained:

> *its caused a lot of fights between her and I and my mom so I hold back with commenting about that because I don't want to start anymore it's like ya know you get the phone calls oh she's mad at you again and it's like leave me alone.*

Some of the women also talked about self-silencing with certain friends as part of the process of maintaining an image they wished to project. Rather than being "at ease" they would take on a narrow persona as Sally explained:

> *So the very close friends like maybe the um two or three that I have that are close friends. I feel like I can be actually um quite comfortable and at ease talking to them. But for other friends it's almost like I go into that professional mode and I think professional, like I think professionally rather than just being comfortable.*

For some of the women, self-silencing with family or friends was influenced by perceived gender roles in that they found it difficult to talk openly with members of the opposite sex because of the perception that men do not talk about or share emotions. As Eleanor explained:

> *I definitely ah feel more ah, I feel it's easier to talk to my mom about relationship then my dad. Ah, I guess he might be a bit old school were ya know you're not supposed to show feelings or anything, so it's definitely easier to talk about relationship with my mom.*

Nevertheless, for the women in the low self-silencing group it was important to have a sense that their friends and family really "knew" who they were. Though they did not always access these other relationships on a regular basis and frequently would censor themselves around others to avoid conflict it was still important for friends and family to understand their needs and interact with them as required. For many of the women in the low self-silencing group it was felt this could be achieved through more casual social interactions with others as Jennifer described "I'd say my friends know exactly who I am because I talk to them more".

Summary

The narratives of each of the women, regardless of group assignment, revealed at least some self-silencing behaviour throughout various relationships with others. They appeared to engage in a delicate exchange of expression and self-silencing, to various degrees. The times

and situations in which high versus low self-silencing women adopt these practices may differ; nevertheless the goal is the same, which is to balance and maintain relationships.

In intimate relationships, the high self-silencing women in the current study appear to censor themselves to avoid unnecessary conflict and take into consideration timing and partner availability when they do share their thoughts and feelings. They also tend to avoid discussing issues that may be important to them if they feel their partner lacks an interest in or knowledge of the subject. In contrast, many of the low self-silencing women in the current study seem to censor themselves more when they feel their partner's needs are more pressing then their own. These women have more of a tendency to label things as "little" and "unimportant" and so may not feel they are self-silencing because they continue to share their feelings on the "larger" topics with their partners. Additionally, the high self-silencing women felt there were ways in which they would like to improve their ability to communicate with their partners, whereas the low self-silencing women felt they already communicated well with their partners and that there was less need to work on that aspect of the relationship.

Both groups of women also appeared to be selective when choosing to share their thoughts and feelings with various friends and family members, but again the motivation for doing so often differed between the two groups. Both of the women in the high self-silencing group appeared to censor themselves most around their friends and family when they were concerned that the other person will not appreciate the things that are important to them or if they were worried the other person will criticize their thoughts and choices. In contrast, several of the low self-silencing women would avoid topics if they worried it could create conflict with family or friends. Surprisingly, low self-silencing women also appeared to censor themselves more according to gender and professional boundaries.

Category 2: Focus on Aspects of Social Support

Topic 1: Importance of Social Support from Partner

During the focus groups much of the discussion centered on the role and importance of social support from various sources, particularly the importance of a supportive partner. The women were asked to talk about the different aspects of support, such as emotional and practical support, that they felt they did or did not receive from their partner. As well, the women in both groups discussed situations in which they would seek more or less support from their partner.

High self-silencing women. Strong support from one's partner was very important for the women in the high self-silencing group. Both Dorothy and Jane emphasized needing a partner who could share in the emotional ups and downs of life. As well, practical support, particularly in the form of sharing in the little day-to-day tasks, was also highly appreciated by these women. Having good partner support was so important that the women felt they would rather be alone then have an unsupportive partner as Dorothy explained when she said:

> *Like it isn't for me it isn't worth having someone who's not going to be supportive. I couldn't do it. I'd rather just do it on my own.*

However, even though they valued support from their partner, they also placed an important emphasis on retaining independence and choice. As Jane explained:

> *I decided I wanted more for myself [. . .] because I want to be in a relationship with someone where I'm not with them because I have to depend on them, I want to be with them because I want to be with them.*

There was also an emphasis on working together with their partner and supporting each other but still being able to be self-sufficient if it came down to it. For Dorothy this meant retaining financial independence as she explained:

> *I think that's a really important motivator for me has always been to make sure that I have the education to get a job and to have that independence, and to make, ah financial decisions. In our relationship right now it's important for me to feel*

that I can, um I have the money to do things for our children and we together can do things for our children. It's important to both of us, both my husband and I.

Nevertheless, the narratives of the women in the high self-silencing group revealed that support from their partners was not always available. There were times when they felt their partners lacked understanding and thus were not able to support them in the way they needed. During these difficult times there was a tendency to take time away from their partner, to be alone and work through things for themselves and then return to work through the problem with their partner. Some of this pattern could be seen as Jane explained the process her and her partner take in resolving her need for more support from him:

Like usually then what ends up happening ya know he'll go away to work and then comes home and, and we can actually talk but it's almost like we need, because usually he goes away for five days at a time, and it's almost like we need that time apart. Like no talking and he thinks about what he said and I think about what I said and then we can talk about it rationally.

Interestingly, though the woman valued support from their partners, they also sought concurrent support from family and friends. If their partner was being mildly unsupportive or they had a disagreement with them, these women would go to friends for support. However, when support from their partner dropped severely they did not necessarily lean on their friends and family more, instead they would often engage in isolating behaviours, such as focusing on housework and minimizing socialization with others.

Low self-silencing women. Support from one's partner was also very important to the women in the low self-silencing groups. In some ways perhaps even more so than for the high self-silencing women because of the emphasis most of the low self-silencing women place on their partner as primary support person. For these women, their partner is their first or preferred choice to go to for most of their support for various reasons as Kate discussed:

> *ya you're much happier if your communicating particularly in a relationship with your partner because that's the person that, for me any way, your whole world revolves around that person so its most important to me that I'm communicating, communicating well with my partner. And its most overwhelming if it's my partner that I'm not communicating well with, and, in as opposed to having a moment of not communicating well with mom or with a friend or something because those relationships as important as they are- are not like the center of my world right now.*

Additionally, these partners were also chosen as the primary person to go to for many types of support. The low self-silencing women found their partners provide not only emotional support, but many aspects of practical support and assistance as Sally discussed:

> *I think ah my partner fills quite a bit of those roles like um I spoiled. He drives me to work, picks me up, he does the laundry, he cleans the house [. . .] The other thing is too I if ah, we do most of my, our talking when I, when we go to, when he drives me to work, when he picks me up after work is kind of my defusing from the day that kind of thing.*

Thus one's partner was considered an important source for practical assistance with daily issues. Practical assistance from one's partner helped not only with the functioning of the family but allowed the individual woman personal time as Kate described:

> *Yah he's really good as far as yah know helping take care of the children and cooking and cleaning and offering support so I can go out for a couple of hours here and there.*

Moreover, for some of the participants their partner had become one of the few, if only, sources of support currently available which means their partner was called upon for support in almost all situations which Jennifer discussed:

> *I can really, like I can't really think of practical support for my situation right now because I don't really know people in my classes. Haven't really got a ride from anyone else other then my boyfriend kind of right now.*

Many of the women in the low self-silencing group also dealt with rifts in support from their partners differently than the high self-silencing women. For these women there was a tendency to try and solve difficulties in support right away by talking about it then and there as could be seen in Eleanor's frustration over her partner not wanting to address things:

> *Sometime I know um let's say we start a discussion my boyfriend he just says that oh I don't want get us um ah I don't want us to get into a fight over this. I'm like we're just talking. [. . .] sometime he doesn't like us to argue and just like I'm just talking about, about it I'm not angry [. . .] Well I think sometime it's just like let's think about it and get back to it later.*

As well, trying to resolve things fairly quickly with one's partner meant one could avoid having to go to secondary supports such as family and friends, a preference which Kate stated: "*I try to resolve it with him so that I don't have to keep bouncing it off other people*".

Topic 2: Importance of Social Support from Family and Friends

The women also were asked to discuss their involvement with their broader support network that includes other individuals such as family and friends. The conversations touched on the role of and importance of both emotional and practical support from others. As well, the women explored the different times and situations when they sought support and whether or not they felt they received the necessary support from others.

High self-silencing women. Having strong relationships and staying in contact with both family and friends was important to the high self-silencing women in the current study. These women tended to maintain wide social networks including, family, long-time friends, co-workers and different peer groups. The women in the high self-silencing group regularly drew on these individuals for different types of support, even when being supported by their partners.

Being able to socialize out of their relationships was important to both of the high self-silencing women as they find support from family and friends gives them different outlets and

experiences while refreshing them in their home lives. For Jane, having supportive friends gave her a sense of "balance" as she explained:

> *if you're just focused about ya know work and your home life and you don't go out at all like that friend social support like you really notice that when it's not around [. . .] if I don't make sure that I go out ya know a couple times a month, at least, then I get really ya know you can get really overwhelmed with what you're focusing on [. . .] if I go out with my girlfriends then when I come back I'm better yah know, I'm a better girlfriend for Matt.*

Moreover, both of the women in this group felt it was important to have female friends who could understand things from a woman's perspective. Even with supportive male partners, it was still crucial to have someone that has shared in the female experience, as Dorothy described:

> *I think it's important to have a woman, another woman friend in your life. Who is ah supportive, and who, who sees men's and women's roles more equal and more ah ya know that everybody should be pitching in. It's important, it's important to have somebody in, in your life. Not someone who's saying, well did you buy the latest blah blah?*

The need to have active and supportive relationships with other women also extended into the high self-silencing women's family relationships. In particular, female relatives were sought as they provide a sense of familiarity, security and understanding as Jane described:

> *then my family I think of my social support as um like when I'm emotionally upset like I go to my mom or my aunt and I can go to them and cry and like be really vulnerable and open.*

Additionally, the women discussed how much they would miss having their friends' around to provide emotional and practical support, even if everything else is going well in their lives. As Dorothy related:

> *I think it's really important because when I don't have that, when I'm not getting, when I haven't had coffee with a friend for awhile or haven't gone out I really miss it and like there's been times in my life when I think ya I'm getting*

> *everything that I need to get done in my life and my career is going well but I miss having that friend that you can talk to.*

The benefits that come from having a variety of social supports that can be accessed, outside of one's intimate relationship, may be the reason why high self-silencing women placed such importance on maintaining external sources of support even when their intimate relationship was strong.

Low self-silencing women. Support from family and friends was also important to the low self-silencing women in the current study but, more often than not, it was used as secondary source of support after partner support. For many of the women in the low self-silencing group, friends were there to provide less personal but still important support in the form of socialization. Although, some of the low self-silencing women may not depend heavily on friends for emotional support they do seem to rely on them as outlets for "fun" as Kate explained:

> *Well I mean, I honesty I have some friends that you just have fun with you don't necessarily agree with the kinds of ways that they think necessarily but they're somebody that you can just have a good time with.*

Although these women used friends for more "casual" or socializing forms of support on a semi-regular basis they did not always go to these friends for more complex support unless their partner was unavailable. For Kate this was often true as she said that she preferred to talk to her partner first but because he works away she sometimes had to choose someone else for the time being:

> *If he's home, he's the first person I'm definitely going to. But because our situation is unique in a sense that I can't even phone him at work if something at home happens that I would like to talk to him first I can't so then it would depend on ya know if it was something to do with my sister it would be my mom, or ya know (laugh)*

Nevertheless, family was still frequently sought by low self-silencing women when practical support was needed. Sometimes this was a matter of geography - when one's family was living with them they could be accessed easily for little things as Sally explained how her son helps her out, "*for rides, my son too, he's 24, if I needed a ride somewhere.*"

Some of the women also had very limited social networks and as a result they would rely primarily on their partner and less on others such as family or friends unless it was really needed or could be obtained. This was true of Jennifer who discussed having few social resources, aside from her partner, since she had moved to a new city:

> *I can agree with that um just because my boyfriend he's the only one that's here, like my family is away, so that's who I live with um so that is the most important um thing*

However for some, strong bonds did develop with the few friends who were available and which made them a good source of support, as seen in Sally's narrative:

> *My friends I'm more um I don't have a whole bunch of friends, I, just very close friends. So the very close friends like maybe the um two or three that I have that are close friends. I feel like I can be actually um quite comfortable and at ease talking to them.*

Summary

There appear to be some differences in the ways the high and low self-silencing women in the current study utilize their social support systems. Women from both groups believe good support from their partner is very important, if not indispensable. However, the role that one's partner's support plays in relation to support from family and friends appears to be different.

For the two women in the high self-silencing group, engaging in and maintain support from a variety of sources concurrently is important. Though one's partner provides a pivotal source of emotional and practical support so do friends and family, so much so that neither

source is necessarily the primary source or support. Female friends in particular are important to the high self-silencing women as they provide needed support and insight from the female perspective. Thus support is sought from many sources at once.

In contrast, many of the women in the low self-silencing group appear to place strong importance on partner support. Support from one's partner is the first or preferred choice making them the primary source of support. Although social support from others, such as family or friends, is also valued it is not relied on in the same way. As well, although friends can provide fun and socializing support at any time, they are not necessarily relied on for more deep emotional support unless one's partner is unable or unavailable for support. Thus the low self-silencing women in the current study have a tendency to use family and friends as a more secondary source of support.

Category 3: Focus on Aspects of Mood

Topic 1: Impact of Support/Non-Support from Partner on Mood

The women in both the high self-silencing and low self-silencing groups were asked to discuss the impact interactions with their partner can have on their mood. In particular, they were asked about what effect good support or poor support can have on how they feel. Though the women in the high self-silencing group felt they silenced themselves more with their partners and utilized their partner's support differently as compared to the women in the low self-silencing groups, in the end, the influences and impact on mood of these interactions were often quite similar between the high and low self-silencing women.

High self-silencing women. When the women in the high self-silencing group felt like their partners were supporting them and working with them towards the same goals, their moods were lifted. In particular, having a partner who could provide both emotional and practical

support led to a more positive mood. Indeed, small gestures of practical support had more impact on improving mood than any lavish store bought gesture as Jane found:

> *Like he's not big on the roses or anything like that like he's never been um big on buying me little things like that but ya I just think or he'll (laughing) clean the bathtub, like I hate cleaning the bathtub, I think he knows it. He sits there and he scrubs it ya know and he does those kinds of things to ya know make you feel better so that's, that's what he does ya.*

Additionally, in some situations one's partners also acted as a sort of regulator against falling into a cycle of negative moods such as too much worry, which Dorothy explained:

> *Ya and my husband also doesn't let me, he doesn't let me worry about things. He's not a big worry man and if I, he sees me getting all worried about something he'll just try to distress that and he as much as possible. He'll say oh lets go for a walk you need to forget about that or ah he'll talk it through with me. He's really big on don't worry about ah things you can't control. I guess that's part of his support.*

Although good support from one's partner could increase positive moods, the opposite was also true. Not receiving the type or amount of support needed from one's partner would lead to feelings of frustration and emotional upset for the women in the high self-silencing group. Moreover, for these women the frustrations that would arise from not having their partner understand their needs would lead them to isolate themselves from their partner and increase mild depressive symptoms as Jane described:

> *ya know its honestly it's almost like you can just become like an emotion less person and your just walking around and your just its like that persons there but your almost ignoring them and its, it's, it's what happens like you just get so frustrated and you can get so upset and you just think like I don't want to deal with that person right now and I don't want to hear what they have to say*

Thus, one's partner can have a significant impact on the moods of high self-silencing women.

Low self-silencing women. As with the high self-silencing group, women in the low self-silencing group found that good support from their partner helped to improve and maintain good moods. From providing a listening ear to helping with daily activities to engaging in fun activities together, partner support was found to be uplifting as seen in Kate's discussion of some of the time she had spent with her partner:

> *The fact that we do a lot of things together my husband and I um, we both hunt a little together, and fish, and downhill ski, and snowmobile, and we do all those kinds of things together. So if I was feeling down after having a day where you spend together like that in such a positive kind of a way then that would help me feel better for sure*

Moreover, for many of the women sharing negative or difficult emotions with their partner was a way to draw in needed support and help alleviate negative moods. For some of the women a good partner was someone who supported her in being more self expressive as Sally had found with her partner "*he's actually encouraging me to ah to when I feel angry to, to swear if I need to swear [. . .] I used to hold that all in*".

Similarly, for Jennifer, the practical gestures were important in addition to emotional support in improving mood:

> *I stayed home most the day crying. He was very um accommodating um he made me lunch, made me dinner, talked to me, um made sure I was ok, um ya know let me vent about it ya know 30 times. Ya know ya he was just, he was great. Um he can see when I'm sad and just help me get out of it.*

Although good support from their partner could raise positive mood, the opposite was also true for low self-silencing women. As with the high self-silencing groups, not feeling supported by one's partner increased frustration and negative moods. Kate said she found it to be "total and absolute frustration" when her partner was non-supportive causing her to feel

uncared for. She found that "being that he's completely like anti-supportive of it it's really frustrating for me and it makes me feel like he doesn't care about me, when we fight about it."

As well, it appeared that these incidents of non-support, which would increase tension in the relationship, may also increase depressive affect, even if only temporarily. Once again Kate explained how fighting with her partner could add to her already sinking moods:

> *I mean there's time that you get overwhelmed with things that are going on in your life and you get depressed if ah if you're fighting with your partner yah know sometimes you could find yourself feeling like that.*

Topic 2: Impact of Support/Non-Support from Family and Friends on Mood

The women were also asked about the impact that support from other people in their lives could have on their moods. As with the impact of partner on mood, the impact that family and friends could have on a woman's mood were similar for both high and low self-silencing women. Although they interacted with their support networks in different ways, women from both groups felt it was important to have good friends and family in their lives and that being cared for by these people increased positive moods. Also, the opposite was also true for both groups of women, negative or hurtful interactions with their support network increased negative moods.

High self-silencing women. For the women in the high self-silencing group, the support and care of friends and family had a sizeable impact on mood, above and beyond what they received from having a supportive partner. Family and friends provided them with alternative perspectives, boosted self esteem and increased a personal sense of empowerment. For Jane, approval and reassurance from her mother has helped her through emotionally tough times that were affecting her intimate relationship, as she explained:

> *it was really, really nice to have my mom um support me and say ya you know what you are worth it and you are worth having a guy who wants to be with you because of who you are and that like gave me such a boost of confidence [. . .]*

> *and gave me self-esteem and it just made me feel better about myself like yes they do support me and um ya know it, it, it does it makes a huge difference ya.*

Furthermore, the women in the high self-silencing group said they found that female friends provided them with a valuable source of support from the female perspective and that this has an important effect on their mood. Support from these friends provided a type of comfort that one's partner might not be able to as Dorothy explained:

> *Well the day my youngest went to full time grade one I thought I would cry my eyes out so I went to my friend's house and her youngest was same age as mine and she had the coffee on (laughter) and we had coffee and that's when those feelings kind of snuck up on me. Ya know, so it was good and I don't think my husband really got it, but my friend did so it was good to have somebody.*

Nevertheless, relationships with family and friends could also have a negative impact on the emotions of high self-silencing women. Not only did a lack of support from others often bring down the moods of these women but having to be supportive of others during difficult times could have an emotional toll as Jane described when she had a difference of opinion with a friend:

> *Just having that disagreement and I find that it can really set everything off balance and um even if it's like that with a close friend if yah know there's something [. . .] I'm like concerned about something in her life [. . .] and I'm really worried for her I do find it's like emotionally like it's hard.*

Consequently, the relationships high self-silencing women have with others in their support network can have significant positive and negative impacts on their mood.

Low self-silencing women. Although low self-silencing women often appeared to use friends and family as a secondary support system, not receiving support from these sources could, nevertheless, be devastating to their mood. Not getting the support they were looking for from family or friends could leave low self-silencing women feeling as if they were uncared for

or unloved, and increased their negative affect. By the time some of the women in the low self-silencing group turn to family or friends for support they might have built up a high level of expectation and when this is not met it can be very upsetting. This was true for Jennifer who frequently discussed how she felt about her mother not supporting her in school:

> *That was like a big thing with school. Like me coming to school, them not understanding that and, even um just not, um I felt like a lot that they didn't support the idea they didn't understand the idea. That might have been because of that they didn't understand so they didn't, didn't know how to show me the support but it does feel like they don't care.*

However, when low self-silencing women did seek support from friends, it often had a positive and empowering effect on them. For Jennifer her partner was her number one support person but she also found getting the support she wanted from friends also added to her sense of empowerment, which she explained "*If I get what social support I'm looking for from them (friends), if I feel really comfortable [. . .] then yah I'm empowered.*"

As well, the women in the low self-silencing group also felt it was important to surround themselves with good "positive" people, which helped them feel better about themselves and more empowered as individuals. As Kate so eloquently summarized:

> *I mean if you surround yourself in people that make you feel good then you generally feel better about your own life so. If, if I'm feeling supported by my friends if I'm feeling like my friends are ah positive people um good people to be around, supportive people um smart people even ya know like that if you were asking for advice the advice that you're getting back is advice that you respect and believe in. Then ya you're going to feel empowered in all of your relationships.*

Summary

Though the high self-silencing and low self-silencing women in the current study are motivated in different ways to sometimes censor their thoughts and feelings in their relationships and to utilize individuals in their social support network differently, in the end much of their

emotional responses appear somewhat similar. Being supported by one's partner is pivotal in improving or maintaining positive moods and the feeling that one's partner is not being supportive can cause significant decreases in mood. Likewise, when required support is received from family and friends it can also increase positive emotions and one's sense of empowerment. However, the women in the high self-silencing group appear to be more continually engaged with many people in their social support network, which may help alleviate the depressive affect they feel with a partner's non-support. Thus it seems, perhaps because of the emotional difficulties that can arise from self-silencing, that the high self-silencing women, at least those from this study, attempt to "spread-out" their support as a possible way to help them deal with the negative emotional impact of non-support from a specific source such as their partner.

DISCUSSION

Study Objectives

Jack's (1991) Silencing the Self Theory suggests that one of the causes for depression in women is their self-silencing in intimate relationship to preserve the integrity of the same relationship. However, given that not all women who self-silence become depressed, it was postulated that a moderating variable, such as the availability of social support outside of the intimate relationship, might be involved. The objectives of the present project were to study social support as a moderating variable in the relationship between self-silencing and depression, and to add a depth of meaning to the quantitative findings through the use of narrative focus groups. Two types of social support (emotional and practical) from two sources (partner and others) were assessed with respect to the amount received and the degree of satisfaction reported by the women in the study.

Quantitative Findings

The pattern of association between social support and depression scores revealed that greater amounts of and satisfaction with the support (emotional and practical) received from the partner were related to lower depression scores in the women in the entire study. However, when considering others (family and friends) outside of the intimate relationship, only emotional support (amount and satisfaction) from these sources was associated with depression scores. Hence, the women who received less and were less satisfied with emotional support from their family and friends reported greater depression scores.

The results also showed that high self-silencing women reported higher levels of depression symptoms, and lower levels of satisfaction and happiness in their intimate relationships than the low self-silencing women. This is congruent with Jack's (1991) Silencing the Self theory and other empirical studies (Jack & Dill, 1992; Thompson, 1995). The high self-silencing women also reported receiving lesser amounts of emotional and practical support from their partner and others in their social network. Not surprisingly, they also reported greater dissatisfaction with the emotional and practical support received from both sources.

It was hypothesized that when social support was low, self-silencing would predict depression such that high self-silencing would be significantly associated with greater depression. However, when social support was high, the relationship between self-silencing and depression would be significantly weaker. The results with the amount of emotional support from both sources (partner and others) showed that regardless of that type of social support, greater self-silencing predicted greater depression. Thus amount of emotional support from partner and others did not act as a moderator in the link between self-silencing and depression. The same observation was made with regards to the other kinds of social support from both

partner and others, namely amount of practical support, satisfaction with emotional support and satisfaction with practical support.

It is difficult to understand why social support does not have implications in the association between self-silencing and depression when the results show that the high self-silencing women were more depressed than the low self-silencing women, and were also more unhappy in their intimate relationship, receive lower amounts of social support from their partner and others, and are less satisfied with their social support network. The lack of confirmation for social support as a moderating variable for depression may in part relate to the use of a community sample, instead of a clinical sample, in the current study. While it is likely that at least some women in a community sample would have clinical levels of depression, this is not equivalent to using a clinical group who has been diagnosed with depression (Patten, 2000). Thus the range of scores on the HAM-D, and the associated severity of symptoms, would likely have been different had a clinically depressed sample had been used. In turn, social support may have had a different effect on a clinical sample with more severe and chronic depression overall.

As well, the current study may not have found support for a moderating effect of social support on the self-silencing / depression relationship because of several features associated with the measurement of the social support variable itself. The range of scores on the social support measure was very limited as the scores for most of the participants responses tended to cluster around the high end of the scale. Although the ratings of social support by the high self-silencing women were, on average, significantly lower than their low self-silencing peers, the scores of the high self-silencing women were still very high overall. That is, regardless of whether they fell into the high or low self-silencing group, most women indicated they received a high level of support and that generally they were satisfied with this support. As a result, it was

not possible in the present study to examine the effect of support across a full spectrum of scores that would include moderate and low levels of support and which could have a different impact on the self-silencing to depression relationship.

Furthermore, given the limited range of social support scores, one might also question the appropriateness of the measures of support for use in the current study. Though attempts were made to test social support in a multifaceted manner by including different elements of support (emotional and practical) and ratings of both the amount of and satisfaction with support, nevertheless it is possible that the current measures did not capture some element of support that would be different for high and low self-silencing women. Even though the SSB has frequently been used in past research on support, perhaps, for the current study it might have been too complex a measure of support (Nezlek & Allen, 2006; Thompson, Kaslow, Short & Wyckoff, 2002). It could be that, when asked to look at so many individual elements of support high self-silencing women are apt to give fairly high ratings to individual items, creating a higher overall score. However, if asked to rate their overall sense of the amount of and satisfaction with the support they receive, without looking at the individual elements, their first impulse may be to rate their support lower. Thus, if a more brief measure of support had been used there may have been a greater range in scores.

Conversely, it may be that social support does not moderate the link between self-silencing and depression. As discussed in the introduction, there are two main mechanisms by which social support is thought to have an effect on depression. The first is explicated in the stress buffering model, which is in essence a moderating effect model whereby social support is postulated to affect the degree to which a variable such as negative life events or as in the current study self-silencing, will impact on depression (Fernandez, Mutran, & Reitzes, 1998). The

current study does not support a stress buffering model as no moderating effect was found. The second mechanism is more direct in nature. As proposed in the main effects model, social support is also thought to impact depression directly (Cohen & Willis, 1985). According to the main effects model, being satisfied with or having a good social support network can have a positive impact on depression directly regardless of the presence or absence of other "stressors". In the current study the results were more supportive of this model as it was found that better social support was related to lower depression scores regardless of the degree of self-silencing and that social support was not a moderator in the self-silencing / depression link.

Qualitative Findings

The second objective of the study was to explore how high self-silencing and low self-silencing women viewed their own levels of communication within their intimate relationships, their social support systems and changes in their moods. This was done through the use of small focus groups which allowed the women to elaborate on the meanings they attribute to these topics which in turn provided an extra level of depth to the quantitative findings. The addition of this section was felt to be important, as various authors have called for the use of more narrative work when examining self-silencing in women (Ali, Oatley, & Toner, 2002). Particularly, the design of the study provided the researchers with a chance to explore the experiences of low self-silencing women and compare them to the experiences of high self-silencing women, which, to the best of our knowledge, had not been done.

Based on the qualitative analysis of part two it appeared that the women in both the high self-silencing and low self-silencing groups engaged in varying levels and elements of silencing in their intimate relationships. However, the motivations behind and expressions of these behaviours appeared to differ between the two groups of women. The high self-silencing women

seemed to refrain from discussing things that were important to them if they were concerned that it would negatively impact their partner or if would start a fight. For these women, self-silencing was used to preserve harmony in the home. Conversely, low self-silencing women were more likely to censor themselves when they felt that the needs and issues of others were more pressing then their own or if they were worried it could cause their partner to view them negatively. For these women, not sharing certain things with their partner was more often a time or image management technique.

Furthermore, the ways in which these two groups of women viewed their engagement in their intimate relationship also differed. Although the narratives of women from both groups revealed incidences of self-silencing, only the women in the high self-silencing group identified that there were times when they found it difficult to share openly with their partners. In contrast, the low self-silencing women viewed themselves as sharing everything with their partners. Thus, it appears that, in addition to acts of self-silencing, for women in the high self-silencing group there was also the element of feeling that they were silencing in their intimate relationship, which influenced how they identified with their silencing.

Both groups of women also appeared to be selective when it came to discussing issues with family and friends. For high self-silencing women, having friends and family to share with was very important yet they would still limit their discussion if they felt the topic could give cause for the other person to negatively evaluate them. These women also had a tendency to limit their discussion with others to areas of common ground where both parties shared similar views so that they would not be criticised for offering opposing opinions. In contrast, low self-silencing women would sometimes refrain from discussing things with others if they felt that it might cause conflict between them and their family or friends. Since it was important to low

self-silencing women to have a friend or family member who would supportively listen to them when required, it was essential to not alienate any of them through conflict and so they would silence their thoughts at times in order to direct the relationship.

Interestingly, when it came to family and friends, both the high self-silencing women and the low self-silencing women agreed there were times when they purposefully self-silenced around these individuals even though it made them feel frustrated by the whole situation. Thus it may not be the actual act of silencing but the feeling that one is silencing one's self that relates to the emotional difficulties associated with self-silencing, which would make sense in relation to Jack's theory. That is, when a woman engages in self-silencing and by doing so feels she is sacrificing herself there is a dissonance between what she feels is right for her and what she feels are morally and culturally sanctioned "shoulds" which leads to a divided sense of self.

Part two of the project also examined the women's narratives relating to social support. It was found that high self-silencing women engaged in their social support networks differently from low self-silencing women. Although both groups of women agreed good emotional and practical support from their partner was important, their utilization of this support varied. For low self-silencing women their partner was the primary and most vital source of support. Not only were they satisfied with the support their partners provided, it was also generally sufficient in meeting their needs. For them support from others was secondary and often only sought when the partner was unavailable. For high self-silencing women, partner support was important but it was also seen as only one part of a wider support network that included friends and family members. Though they felt their partners were supportive of them, high self-silencing women would continually and simultaneously engage different members of their networks, thus pulling in different elements to help them feel more supported on a regular basis.

These qualitative findings in relation to social support may in part explain why no significant moderator effect from support was found during part one of the study. It appears from the narrative data that some women continue to engage in high levels of self-silencing regardless of having diversified support systems. This may relate to the proposal by Jack (1991) and others (Gilligan, 1982) that women, particularly high self-silencing women, have a relational sense of self. That is women's development of their sense of self stems out of their connectedness to those around them. It may be that a wide network can help foster one's sense of self in connection to the support of others, particularly if one's partner is felt to be insufficiently supportive, but such networks do not impact on the level of self-silencing within the intimate relationship. Thus in spite of and perhaps even because of the influences of a diverse social networks high self-silencing women continue to engage in silencing behaviours and are not buffered by social support against ensuing depression.

The analysis of the focus group narratives also focused on the women's discussions of mood. Interestingly, the emotional reactions of many of the women, regardless of group assignment, were similar. When the women felt like their partner was being non-supportive it increased feelings of frustration and anger, often directed towards the partner. Conversely, support from the partner not only improved the woman's positive feelings towards him but increased her overall mood as well.

However, the different behavioural reactions in response to a decline in positive mood may partially explain why high self-silencing women tend to have greater depressive symptomatology. In the current analysis it appears that when low self-silencing women have a conflict with their partner they attempt to engage in approach and problem-solving behaviours which, when enacted correctly, are related to reduced depressive symptoms (Nezu & Ronan,

1985). The low self-silencing women wanted to resolve conflict issues as soon as possible so things can go back to "normal". In contrast, women in the high self-silencing group, when faced with partner conflict, engage in more withdrawal and ruminative behaviours that studies have shown can exacerbate depression in women (Nolen-Hoeksema, 1991). Thus, even with a similar emotional reaction the behavioural reactions of high self-silencers may increase and prolong negative moods.

Strengths and Limitations

There were a number of strengths and limitations to the current study. The first strength was the use of both quantitative and qualitative methods, which increased the interpretability of the findings. Although each of the parts could have stood on their own, in combination they provided a stronger more multifaceted view of self-silencing. Not only was this study able to explore the statistical relationships between the variables but it was also able to further contextualize the meanings of those relationships through the use of the narratives from the focus groups.

The sample of participants used for the study had both benefits and limitations. The inclusion of community members, instead of a purely university student sample, was beneficial as it added diversity in age, social economic status and type of relationship to the study. Even so, this sample had limitations. Although some individuals scored very high in terms of depression this is not equivalent to using a clinical sample wherein all the subjects would be classified as having significant levels of depression. As well, there was a very restricted range on the ratings of social support with most participants rating their level of support very high which may be related to the overall mild ratings on the HAM-D. Thus, it may be beneficial in the future to consider using a strictly clinically depressed sample. The current study was also

limited by the number of participants in both sections. Even though there were enough participants to run the hierarchal regression it was, in essence, the bare minimum that would have been needed and having a larger sample may have provided more clear or significant results. Moreover, participants for the focus groups were selected from volunteers who participated in the first part and the limited number of participants in this section resulted in a very small selection pool for the second part of the study. As a result, only six women ended up participating in the focus groups, which was about half the number of participants that was originally planned for. This would restrict the validity and generalizability of the findings.

The method of data collection for part one proved to be both a strength and a limitation in the current study. One benefit to the use of an electronic online survey program, such as Survey Monkey, is that it allowed participants to quickly and easily access the questionnaire from anywhere with an internet connection. This was particularly useful when recruitment was expanded across Canada. Potential participants did not have to wait to receive a paper copy of the survey, nor did they have to worry about mailing it back. This was also advantageous for the actual recruitment as it allowed participants to tell friends they thought might be interested by "word-of-mouth" or more specifically "word-of-email" about the study and send them the link to the companion web-site where the questionnaire could be directly accessed. Nevertheless, there were also some significant problems with the use of the electronic questionnaire in the current study. Specifically, due to errors associated with the use of the program, a portion of the responses were lost early on in the collection period which meant that a number of questionnaires were not sufficiently completed for use in the study. However, this may be seen as more of a situational limitation caused more by the inexperienced use of the data collection method than the method itself.

Another limitation of the study was the use of semi-structured participant directed focus groups with an inexperienced facilitator. Although the use of participant directed groups is recommended as a way to give voice to the participants' views over those of the facilitator and have even been recommended by Jack (1999) it resulted in less focused narrative results. Such results may be suited to a more longitudinal in-depth study of women's voice but were less appropriate to the brevity of the current study. Thus, the results of this study must be viewed in context of the aforementioned limitations of the current work.

Conclusions

Consistent with a number of previous studies (Jack & Dill, 1992; Thompson, 1995) and with Jack's (1991) original theory, the current study found that the level of self-silencing in women was predictive of the level of depression. That is, women with high self-silencing scores were also likely to have higher depression scores. Compared to their low self-silencing counterparts, they also reported lesser degree of marital satisfaction and happiness, and lower levels of support (emotional and practical) from their partners and other people (family and friends) in their network. Not surprisingly, the women in the study who reported receiving more and being more satisfied with the support they receive from their partners and others in their network also reported experiencing a lesser degree of depressive symptoms. This is consistent with much of the literature that reported that social support can act as a defence against depression (Power, 1988; Vidler, 2005). However, contrary to the main predictions of the study, neither the amount nor the level of satisfaction with partner or other's social support directly moderated the link between self-silencing and depression in women. .

Analysis of the qualitative section of the study revealed that, while women in both the low and high self-silencing groups reported engaging in varying degrees of self-silencing in their

intimate relationships they would do so for different reasons. It appeared that the women with low levels of self-silencing viewed themselves as good communicators and their self-silencing behaviours were less frequent and limited to fewer situations, such as when they were concerned about the other person's wellbeing. Whereas for the women in the high self-silencing group, the behaviours were more common and, consisted with Jack's (1991) theory, the silencing was used to avoid conflict, to ensure their partner's needs and happiness were taken care of and to generally "keep the peace" in the relationship. Likewise, the qualitative results also found that low self-silencing women viewed and engaged in their social support network differently than their high self-silencing counterparts. While low self-silencing women depended primarily on their partners for support, high self-silencing women tended to utilize multiple sources of support concurrently. Lastly, though the utilization of one's support network differed, the impact of social support on mood was similar for both low self-silencing and high self-silencing women. When the women in the focus groups felt they were not being supported by their partners they reported it had a negative impact on their mood. As well, the availability of emotional support from others, having a friend or family member who would listen and be caring, was felt by all of the women in the focus groups to have a positive impact on their moods.

Recommendations for Future Directions

A number of recommendations could be suggested for any future research that stems directly from the present work. First is the issue of the type of participant sample used in the study. Though a relatively diverse community sample was used, this is not necessarily equivalent to using a clinically depressed sample which may offer different results. Moreover, Jack's (1991) original work was conducted with women with significant depression who were in treatment and thus the form and function of their self-silencing may be different for these women

as compared to the community sample. While some of the women in the current study scored very high on the HAM-D, one score on a self-report measure is not equivalent to a diagnosis of depression (Myers, & Weissman, 1980). The use of a single measure is not sufficient to establish a full diagnosis nor does it rule out alternative diagnoses. Future work could be aided by including the use of more clinical samples and work could even focus on direct comparisons of the two types of populations.

Continuing research on self-silencing could also focus on further testing Jack's theory with different populations and thus expanding the generalizability of the theory. Jack's original work focused on clinically depressed women in heterosexual intimate relationships which limits her original findings to similar populations. Since then, research on self-silencing has expanded to include community and university samples of women, women with specific disease such as irritable bowel syndrome and some studies have even included men (Ali et al., 2000; Duarte, & Thompson, 1999; Page, Stevens, & Galvins, 1996). However, the applicability of Jack's theory to different groups of women needs to be further examined. To start, research is lacking on the applicability of self-silencing theory to women in same-sex relationships. How do the dynamics of self-silencing change when two women, both with the potential to self-silence, are involved? As well, one might also be interested studying possible generational differences in self-silencing. Since the schemas and self enforced rules related to self-silencing are largely influenced by culture, how do changes in our societies greater cultural standards and views on women impact on the prevalence of self-silencing. For example, are there generational differences between women within the same family?

Future work should also continue to include the use of qualitative methods such as focus groups and interviews. This type of work provides not only answers about group differences but

highlights the individual subtleties between high and low self-silencing women. Potential areas for narrative work to focus on could include a more in-depth review of the communication patterns within high and low self-silencing women's relationships with partner and others. For example, more time could be spent examining if there are specific topics that cause the women to self-silence more and what they feel the consequences might be should they bring these topics up. As well, more attention could also be placed on understanding the formation and workings of the women's intimate relationships. Focus could be placed on how they came to choose their partners and how they view their partners' contributions to their relationships and communications.

Additionally, future studies may also consider studying women's self-silencing and social support by including the perspective of the intimate partner and looking at the dynamics of the couple. Research involving couples could compare and contrast the views and beliefs of both members pertaining to communication and self-silencing within the relationship. For example, one might consider if the partners of high self-silencing women feel there is not enough communication in the relationship and, if so, how do they react to that? As well, if a woman is high on self-silencing and is less able to ask for support for herself, how does her partner know when to give support? Additionally, the relationship dynamics of couples where the woman self-silences could be looked at. Are there certain types of relationship styles, such as a less egalitarian type, that are more likely to foster self-silencing (Fitzpatrick, 1988)? These and other similar topics could be examined through the use of both individual and couple questionnaires and interviews.

Drawing from the current studies' examination of both high and low self-silencing women, future work could also focus more on low self-silencing women and what, other than the

silencing itself, makes them different from their high self-silencing counterparts. If low self-silencing women appear to engage in some degree of silencing as was found in the present study, how do they interpret their self-silencing behaviour and how do they label it? As well, why do low self-silencing women report higher levels of support from their partner and others? Continuing research could examine whether low self-silencing women solicit more support or if they are simply more receptive to the support than high self-silencing women.

As well, it might be helpful to look for possible differences among high self-silencing women in order to more clearly understand the dynamics of self-silencing. For example, do some women have a naturally more reserved disposition that could cause them to be mislabelled as "high self-silencing" when they are not truly silencing themselves according to Jack's model? If these women are comfortable with being less communicative in their intimate relationships do they have the same sense of being split between their true inner self and their outer appearances and the same increases in depressive symptoms? One way to look for this and other patterns would be to examine more closely the individual scales on the STSS, which was not done in the current study. Perhaps, women who are reserved but not self-silencing, in the true sense of Jack's model, may score significantly lower on the Divided Self scale but still score high over all. Future research could focus on finding and analysing the meanings of these possible sub-scale patterns.

Though the current study did not find social support to serve as a moderator between self-silencing and depression, the results do suggest the need for continuing research on the topic. One possibility is the option of other possible moderators. If social support does not seem to alter that connection between self-silencing and depression, what else might? One possibility is the influence of other co-morbid mental health issues. For example, pre-existing anxiety may

have an impact on some high self-silencing women's impressions of their situation and their own self-silencing which may in turn exacerbate depressive symtomatology. Furthermore, there may be some grounding for this already as depression and anxiety are often co-morbid (Gorman, 1998). More specifically, anxiety disorders have been found to precede first episodes of depression (Fava, et. al., 2000) and the presence of some anxiety disorders is associated with greater depressive severity and impairment in those with depressive disorders (Brown, Schulberg and Shear, 1998).

As well, one might consider examining the possibility that social support is not a moderator rather that it may be acting as a mediator between self-silencing and depression. Considering that depression was correlated with both self-silencing and social support but no moderator effect was found for social support in the self-silencing / depression relationship, it is possible that social support might instead act as a mediator. According to Baron and Kenny (1986) "a given variable may be said to function as a mediator to the extent that it accounts for the relation between the predictor and the criterion (pg. 1176)". In such a case there would not be a direct relationship between self-silencing and depression rather it would be that self-silencing impacts social support and in turn social support affects depression. If social support does have a mediating effect, then one would test this hypothesis statistically by using multiple regression techniques to determine whether the significant relationship that was found between self-silencing and depression would no longer be present or would be7 reduced when the mediator is controlled for (Baron & Kenny, 1986). If such a situation was found to be true this would be strong evidence indicating that social support is acting as a mediator, not a moderator, between self-silencing and depression.

It may also be advantageous for future work on self-silencing to explore more deeply the interpersonal relationships and intimate partners of women who are high on self-silencing. The current study found that high self-silencing women reported lower support from their partners and depended on them as only a small part of their support network. Thus, the question may be raised as to why. Studying the partner could also touch on why high self-silencing women feel it necessary to receive support concurrently from a number of sources and seem unable to be comfortable solely with the support of their partner as low self-silencing women are.

Finally, it would be helpful to investigate the temporal sequence of self-silencing and depression to establish which comes first. Using different methods, including longitudinal studies, it would be interesting to follow the developmental path of self-silencing. That is, to see if self-silencing develops first as a pattern of communication in one's intimate relationship, which then leads to depression, or, if a history of depression is present prior to the increase of silencing behaviours in one's relationships. Depression would then be seen as more of a catalyst for more self-silencing. This might have implications for interventions in depression in women who self-silence.

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Table 1
Demographic Characteristics of the Pooled Sample and by Group

Demographic characteristics	High self-silencing group (n = 41)	Low self-silencing group (n = 70)	Pooled Sample (N = 118)
Age (years)	M = 29.63 (SD = 7.37)	M = 28.09 (SD = 6.65)	M = 28.94 (SD = 6.36)
Relationship duration (months)	M = 77.88 (SD = 69.15)	M = 66.87 (SD = 48.45)	M = 71.41 (SD = 57.18)
Marital status (frequency)			
Married	19 (*46.34%*)	38 (*54.29%*)	59 (*50.00%*)
Common-law	12 (*29.27%*)	16 (*22.86%*)	32 (*27.19%*)
Intimate relationship	10 (*24.39%*)	16 (*22.86%*)	27 (*22.88%*)
Number of children			
None	29 (*72.50%*)	55 (*79.71%*)	90 (*77.59%*)
One	2 (*5.00%*)	6 (*8.70%*)	8 (*6.90%*)
Two	6 (*15.00%*)	5 (*7.25%*)	12 (*10.34%*)
Three	3 (*7.50%*)	2 (*2.90%*)	5 (*4.31%*)
Four	0	0	0
Five	0	0	0
Six	0	1 (*1.45%*)	1 (*.86%*)
Ethnicity			
Aboriginal	2 (*4.89%*)	3 (*4.29%*)	5 (*4.24%*)
Asian	3 (*7.32%*)	1 (*1.43%*)	4 (*3.39%*)
Black	0	0	0
Latin	0	2 (*2.86%*)	2 (*1.69%*)
White	35 (*85.37%*)	61 (*87.14%*)	102 (*86.44%*)
[a]Other	1 (*2.44%*)	3 (*4.29%*)	5 (*4.24%*)
Highest educational level			
High School	11 (*27.50%*)	5 (*7.35%*)	16 (*13.91%*)
College	4 (*10.00%*)	7 (*10.29%*)	11 (*9.57%*)
Undergraduate University	11 (*27.50%*)	26 (*38.24%*)	38 (*33.04%*)
Post Graduate	14 (*35.00%*)	30 (*44.12%*)	50 (*43.48%*)
Employment status			
Full or part time	29 (*70.73%*)	36 (*51.43%*)	69 (*58.47%*)
Homemaker	2 (*4.88%*)	3 (*4.29%*)	5 (*4.24%*)
Unemployed	1 (*2.44%*)	2 (*2.86%*)	3 (*2.54%*)
Disability	1 (*2.44%*)	0	1 (*.85%*)

Maternity Leave	0	2 (*2.86%*)	2 (*1.69%*)
[c]Other	0	1 (*1.43%*)	1 (*.85%*)
Educational Status			
Student	21 (*51.22%*)	43 (*61.43%*)	69 (*58.47%*)
Non-student	20 (*48.78%*)	27 (*38.57%*)	49 (*41.50%*)
Income			
Under $10,000	0	3 (*4.35%*)	4 (*3.45%*)
$10,000 to $25,000	5 (*12.50%*)	10 (*14.49%*)	15 (*12.93%*)
$25,000 to $50,000	15 (*37.50%*)	16 (*23.19%*)	31 (*26.72%*)
$50,000 to $75,000	9 (*22.50%*)	18 (*26.09%*)	32 (*27.59%*)
$75,000 to $100,000	4 (*10.00%*)	9 (*13.04%*)	14 (*12.07%*)
Over $100,000	7 (*17.50%*)	13 (*18.84%*)	20 (*17.24%*)

[a]Ethnicity "other" specified by participants included Jewish, Native South American and those with bi or multi cultural identification

[b]Percents for employment may equal greater than 100% as many of the participants were both students and were employed either full or part time

[c]Employment "other" as specified by participants included member of a sustainable living community (commune)

Table 2
Demographic Characteristics of Focus Group Participants

Name [a]	Age	Marital Status [b]	Relationship Duration [c]	Number of Children	Ethnicity
Dorothy	44	M	240	2	Aboriginal
Eleanor	27	IR	48	n/a	White
Jennifer	23	M	14	0	White
Jane	25	CL	18	0	White
Kate	32	M	60	3	White
Sally	43	CL	94	2	Aboriginal

[a] Pseudonyms were used
[b] Marital Status: M = Married, CL = Common Law, IR = Intimate Relationship
[c] Relationship Duration is in months

Table 3

Assessment of Multicollinearity (r >.90) By Way Of Bivariate Correlations Among Variables (N = 118)

Scale	1	2	3	4	5	6	7	8	9	10	11	12
1. HAM-D		.42	-.40	-.35	-.23	-.23	-.25	-.16	-.30	-.22	-.25	-.16
2. STSS			-.46	-.43	-.44	-.39	-.25	-.23	-.51	-.41	-.28	-.23
3. H-QMI				.84	.71	.16	.58	.28	.72	.06	.58	.30
4. Q-QMI					.71	.20	.58	.27	.70	.05	.57	.28
5. EA-Partner						.43	.77	.37	.81	.20	.66	.33
6. EA- Other							.41	.73	.28	.71	.28	.53
7. PA-Partner								.52	.60	.11	.70	.36
8. PA-Other									.28	.46	.26	.62
9. ES-Partner										.21	.62	.28
10. ES-Other											.10	.41
11. PS-Partner												.35
12. PS-Other												

1. Hamilton Depression Rating Scale
2. The Silencing the Self Scale
3. Rating of overall happiness on the Quality of Marriage Index
4. The ratings of quality on the QMI
5. Amount of emotional support from partner
6. Amount of emotional support from others
7. Amount of practical support from partner
8. Amount of practical support from others
9. Satisfaction emotional support from partner
10. Satisfaction emotional support from others
11. Satisfaction practical support from partner
12. Satisfaction practical support from others

Table 4

Bivariate Correlations Among Depression, Self-Silencing, Marital Quality and Social Support Scores (N = 111)

Scale	1	2	3	4	5	6	7	8	9	10	11	12
1. HAM-D		.43**	-.43**	-.35**	-.24*	-.26**	-.28**	-.16	-.33**	-.25**	-.27**	-.14
2. STSS			-.50**	-.47**	-.49**	-.40**	-.27**	-.25**	-.56**	-.42**	-.28**	-.26**
3. H-QMI				.82**	.67**	.19	.53**	.22*	.69**	.11	.57**	.18
4. Q-QMI					.66**	.22*	.53**	.21*	.66**	.11	.56**	.14
5. EA-Partner						.47**	.74**	.30**	.78**	.23**	.67**	.19
6. EA- Other							.43**	.78**	.30**	.74**	.30**	.61**
7. PA-Partner								.47**	.55**	.16	.70**	.27**
8. PA-Other									.21*	.52**	.24*	.60**
9. ES-Partner										.30**	.63**	.16
10. ES-Other											.12	.52**
11. PS-Partner												.32**
12. PS-Other												

** Correlation is significant at the 0.01 level (2-tailed)

* Correlation is significant at the 0.05 level (2-tailed)

1. Hamilton Depression Rating Scale
2. The Silencing the Self Scale
3. Rating of overall happiness on the Quality of Marriage Index
4. The ratings of quality on the QMI
5. Amount of emotional support from partner
6. Amount of emotional support from others
7. Amount of practical support from partner
8. Amount of practical support from others
9. Satisfaction emotional support from partner
10. Satisfaction emotional support from others
11. Satisfaction practical support from partner
12. Satisfaction practical support from others

Table 5
Means (Standard Deviations) for Social Support Variables by Group

Variable	Low self-silencing (n = 70)	High self-silencing (n = 41)	Total sample (N = 111)
Emotional Support - Partner			
Amount	4.74 (.35)	4.10 (.87)	4.50 (.67)
Satisfaction	5.61 (.60)	4.61 (1.30)	5.24 (1.04)
Emotional Support - Others			
Amount	4.33 (.47)	3.81 (.62)	4.14 (.58)
Satisfaction	5.07 (.60)	4.31 (.1.02)	4.79 (.93)
Practical Support - Partner			
Amount	4.74 (.40)	4.45 (.69)	4.63 (.54)
Satisfaction	5.76 (.67)	5.22 (.1.41)	5.56 (.1.03)
Practical Support - Others			
Amount	4.27 (.53)	3.96 (.65)	4.15 (.60)
Satisfaction	5.40 (.65)	5.01 (.96)	5.26 (.79)

Note. Amount of support was assessed with a 5-point scale (1 = no one would do this, to 6 = most would certainly do this) whereas satisfaction with support was assessed on a 6-point scale (1 = very dissatisfied, to 6 = very satisfied)

Table 6
Hierarchical Multiple Regression Analysis for STSS, EA-others, EA-partner and 2-way Interaction Variables Predicting HAM-D

Variable	B	SE B	β
Step 1			
STSS	5.40	1.98	.29
EA-partner	-.53	1.05	-.05
EA-others	-1.00	.96	-.11
Step 2			
STSS x EA-partner	-.14	2.51	-.03
STSS x EA-others	3.45	1.91	.61

Note. $\Delta R^2 = .14$ = for Step 1; $\Delta R^2 = .03$ at Step 2.
EA-partner = amount of emotional support from partner
EA-others = amount of emotional support from others

Table 7
Hierarchical Multiple Regression Analysis for STSS, PA-others, PA-partner and 2-way Interaction Variables Predicting HAM-D

Variable	B	SE B	β
Step 1			
STSS	5.86	1.75	.31
PA-partner	-1.92	.96	-.20
PA-others	-.16	.95	-.02
Step 2			
STSS x PA-partner	2.87	1.99	.51
STSS x PA-others	.85	1.90	.14

Note. $\Delta R^2 = .16$ = for Step 1; $\Delta R^2 = .03$ at Step 2.
PA-partner = amount of practical support from partner
PA-others = amount of practical support from others

Table 8
Hierarchical Multiple Regression Analysis for STSS, ES-others, ES-partner and 2-way Interaction Variables Predicting HAM-D

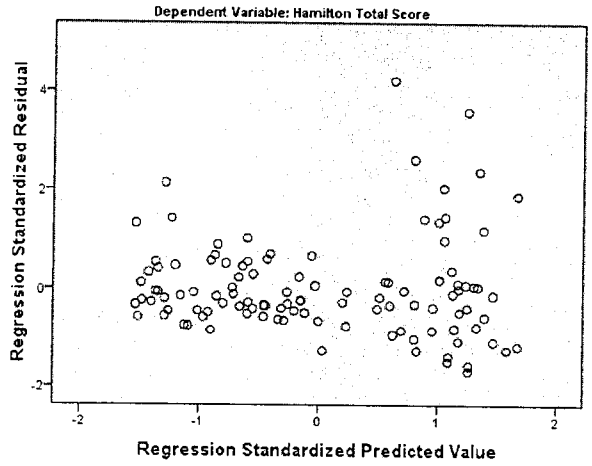
Variable	B	SE B	β
Step 1			
STSS	4.33	1.98	.23
ES-partner	-1.85	.99	-.19
ES-others	-.92	.87	-.10
Step 2			
STSS x ES-partner	1.15	2.26	.20
STSS x ES-others	2.04	1.75	.37

Note. $\Delta R^2 = .17$ = for Step 1; $\Delta R^2 = .01$ at Step 2.
ES-partner = satisfaction with emotional support from partner
ES-other = satisfaction with emotional support from others

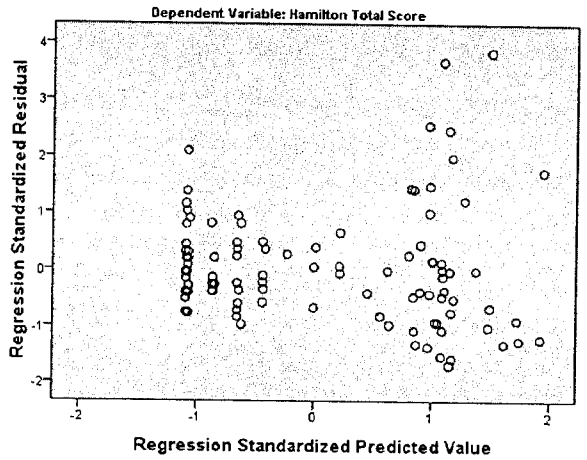
Table 9
Hierarchical Multiple Regression Analysis for STSS, PS-others, PS-partner and 2-way Interaction Variables Predicting HAM-D

Variable	B	SE B	β
Step 1			
STSS	5.85	1.75	.31
PS-partner	-1.69	.86	-.19
PS-others	-.06	.93	-.01
Step 2			
STSS x PS-partner	.170	1.95	.03
STSS x PS-others	2.64	1.90	.44

Note. $\Delta R^2 = .16$ = for Step 1; $\Delta R^2 = .02$ at Step 2.
PS-partner = satisfaction with practical support from partner
PS-other = satisfaction with practical support from others



a)



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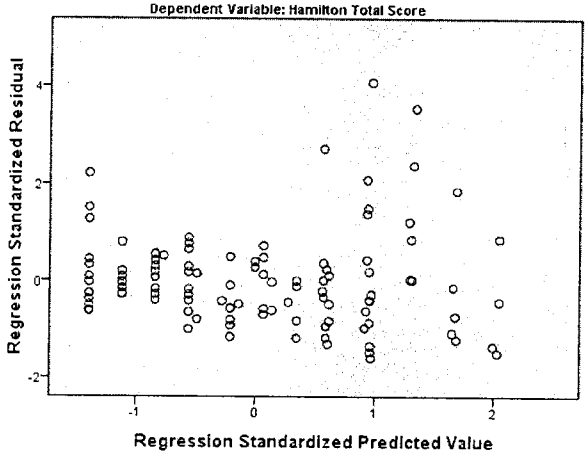
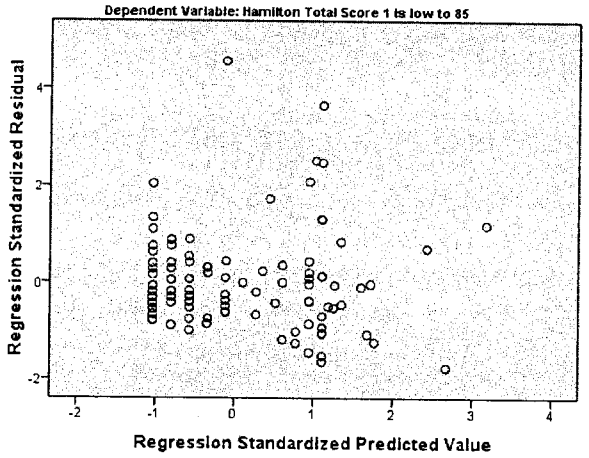


c)



d)

Figure 1. Residual scatterplots from regression analysis of a) amount of emotional support from partner and others b) amount of practical support from partner and others c) satisfaction with emotional support partner and others d) satisfaction with practical support partner and others

Appendix A

Advertisement for Lakehead University's Community Bulletin

Recruitment advertisement for Lakehead University's Community Bulletin

The Department of Psychology is recruiting participants for a research project that looks at how a woman's relationships and social support relate to her mood and psychological well-being. The researchers would like to hear from as many women as possible who are between the ages of 18 and 45 and living within a heterosexual relationship (marriage, common-law) that is at least one year old. Participants will be entered into three random prize draws of $50. For more information, please contact Jessica at psychologystudy07@gmail.com, or visit http://psychologystudy07.googlepages.com. Our recruitment phase will run until <specific date will be given, depends on when ethics clearance can be obtained>.

Appendix B

Script to Recruit Volunteers from Lakehead University's Undergraduate Psychology Classes and from Confederation College

Hello! My name is Jessica Johnson and I am a Master's student here with the Clinical Psychology program. I am looking for volunteers to help me with my research that looks at how a woman's relationships and social support relate to her mood and psychological well-being

We want to hear from as many women as possible who are between the ages of 18 to 45, and who are presently living within a heterosexual relationship that is at least 1 year old. For example you could be married, in a common law relationship or have a boyfriend but you must also be currently living with this partner.

If you are interested in the study, all you have to do is fill out a questionnaire - it takes 30 to 40 minutes. We have hard copies that you can fill out. You can also go to our website to complete it. I have information here (show pieces of paper) that tells you where to get the hard copies and how to access to the website, and how to return your answers to us. Introductory Psychology students get 1 bonus point for their participation. Everyone participant gets entered into three $50 random prize draws.

I also have a 2nd part to this study that involves getting a few people back for a small group discussion on social support and communication within relationships and how it relate to a woman's mood and well-being. You are not forced to participate in the 2nd part if you fill out the questionnaire. There is a place in the questionnaire where you can indicate your interest in Part 2 if you want to be part of the discussion. Introductory Psychology students get 1 bonus point for their participation, if the group discussion takes place before your course ends. All Part 2 participants are entered into two $25 random prize draws.

For both the questionnaires and Part 2, all responses are confidential and no identifying information will be kept.

If you have any other questions you can email me at psychologystudy07@gmail.com

Thanks for your time.

Paper Reminder Handouts for Students

Study on *"Women, Intimate Relationships and Social Support"*

Seeking women between the ages of 18 and 45 to volunteer

Must be currently in an intimate heterosexual relationship of at least one year and living with this partner.

For more information, or to volunteer

Visit our website at http://psychologystudy07.googlepages.com

Or email Jessica at

Psychologystudy07@gmail.com

Hard copies of the questionnaire can picked up and returned in Room 1042 School of Nursing Building, outside the Psychology Main Office. Hard copies can also be requested from Jessica by emailing her at the above.

Appendix C

Recruitment Poster

Department of Psychology, Lakehead University

RESEARCH PARTICIPANTS NEEDED FOR A PSYCHOLOGY STUDY

We are looking for volunteers to take part in a study that will examine how *women's relationships* and social support affect mood.

To participate, you must be a *woman aged 18-45*, currently in a heterosexual marriage or significant intimate relationship (of at least one year) and living with this partner.

As a participant in this study, you would be asked to fill in a research questionnaire that should take 30-40 minutes to complete. The questionnaire is confidential and can be completed online or in paper format which can be mailed back or dropped off at a designated drop point. Participants will also be invited to participate in a second phase of the study that will involve small group discussions to investigate how social support can affect relationships and mood. Those who participate in the questionnaire are not obligated in anyway to participate in the group discussions. However, interested individuals may be called back for the second phase.

All responses are kept confidential. All participation is voluntary.

All respondents to the research questionnaire will be entered into three $50 random prize draws. All individuals who attend the group discussion will be entered into an additional two $25 prize draws.

The first part of the study will run from Aug 4th until August 27th 2008

For more information about this study, or to volunteer for this study,
Visit the Website at http://psychologystudy07.googlepages.com *(don't put www.)*

Or contact JESSICA at psychologystudy07@gmail.com or call us at 343-8168

Jessica
psychologystudy07@gmail.com
psychologystudy07.googlepages.com
Jessica
psychologystudy07@gmail.com
psychologystudy07.googlepages.com
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psychologystudy07.googlepages.com

Appendix D:

Information to be provided over the telephone when contacting community organizations

Information to be Addressed During Initial Phone Contact with Community Organizations

- Name and program (Jessica Johnson, Master's program in Clinical Psychology at Lakehead University)
- Presently seeking the help of their organization in recruiting participants for a study on women, intimate relationships and social support.
- Would like to post flyers or brochures (which will be provided to them) in their lobby/reception area where they may be seen and read by their clients, in the hopes that their clients would contact the researchers for further information if they are interested in the study.
- Provide specific information about the project to help inform their decision including:
    - Seeking women between the ages of 18-45, currently in an intimate heterosexual relationship of at least one year and living with this partner
    - The project is being supervised by Dr. Josephine Tan, a psychology faculty member at Lakehead University and a practicing clinical psychologist registered in Ontario.
    - This research project has been approved by the Ethics Committee at Lakehead.
    - It is a two part study. The first part involves filling out a confidential questionnaire. The second part involves focus group discussions. Participation in the first part does not obligate anyone to participate in the second part. There are no risks or benefits associated with participating.
    - Answer any other questions they may have
- Can submit to them a copy of the poster and brochure for their perusal
- Provide contact information (for Jessica psychologystudy07@gmail.com, http://psychologystudy07.googlepages.com and phone number for Dr.Tan -tel: 346-7751)

Appendix E

Formal Letter to Community Organizations

Date
Name of recipient
Name of organization
Address of organization
Thunder Bay, ON
Postal Code

Dear _____ (Name):

My name is Jessica Johnson and I am a graduate student in Clinical Psychology at Lakehead University. I am currently recruiting volunteer research participants for my thesis study that looks at how a woman's relationships and social support relate to her mood and psychological well-being.

I would be grateful for any help you can provide me in my recruitment efforts to reach as many women as possible. All that it would involve is permission from you to post or display in your reception area the recruitment flyers. A copy is enclosed for your examination. I am hoping that in reading the flyer, some of your clients might contact us for more information about the study.

The project is being supervised by Dr. Josephine Tan (tel: 346-7751), a psychology faculty member at Lakehead University and a practicing clinical psychologist registered in Ontario. This research project has been approved by the Ethics Committee at Lakehead University (see enclosed ethics approval). Research participation in the project involves filling out a questionnaire package that is available online through our web site at http://psychologystudy07.googlepages.com Alternatively, paper copies of the questionnaire can be obtained by contacting the researchers. Those who indicate an interest in going further in the study might be contacted for a confidential focus group to discuss the meaning of social support.

There is no risk or harm to the participants as a result of completing the research questionnaire or being part of a group discussion. However, Dr. Tan and I will be available so that participants may approach us with any concerns, or for further information. All responses from the participants will remain confidential. Participation is entirely voluntary which means the people can drop out of the study any time they wish.

I will follow up on this letter with a telephone call in a few days' time to see if you have any questions for me. Thank you very much for your attention in this matter.

Sincerely,

Jessica Johnson, HBA
MA student in Clinical Psychology with Specialization in Women's Studies
Psychology Dept. Lakehead University
Email: psychologystudy07@gmail.com
Tel: 343-8168

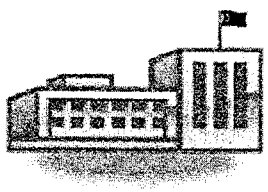
Appendix F

Recruitment Brochure

For more information or to participate, please visit:

http://psychologystudy07.googlepages.com

Thank you for considering our study



Lakehead University
Department of Psychology
Attention: Jessica Johnson

955 Oliver Road,
Thunder Bay, ON
P7B 5E1
Office - SN 1042

psychologystudy07@gmail.com

http://psychologystudy07.googlepages.com

(no www. before the address)

Attention

Research Participants Needed

We are looking for women to participate in a study on relationships and mood

Ψ

Interested in Volunteering?

We are looking for women to participate in a study on relationships and mood. We are looking for women who are:

- Between the ages of 18 and 45
- Are currently in an intimate heterosexual relationship (marriage, common-law etc) of at least one year
- Are living with this partner at the present time

Study Information

We are investigating how women's perceptions of their social support resources are related to their intimate relationship and their moods

Involvement

Volunteering will involve completing a confidential survey that will ask you about such things as your mood and what kinds of social support you have. The survey can be completed online through our website http://psychologystudy07.googlepages.com (*no www. before the title*) or by filling in a paper copy which can be obtained from the Lakehead University Psychology office (SN 1042), during in-class recruitment, or by contacting the researcher at the email or address below

Lakehead University
Department of Psychology
Attention: Jessica Johnson

955 Oliver Road,
Thunder Bay, ON
P7B 5E1
Office - SN 1042

psychologystudy07@gmail.com
http://psychologystudy07.googlepages.com

Additionally, volunteers that have completed the survey may be invited to participate in a vital second phase of the study that will involve small discussion groups. Participating in the questionnaire of the first part in no way obligates anyone to participate in the discussion groups

For more information please visit our website at http://psychologystudy.googlepages.com or contact:

Jessica Johnson at psychologystudy07@gmail.com or Dr. J. Tan at josephine.tan@lakeheadu.ca

Appendix G

Recruitment Advertisement in the Media

Recruitment advertisement for community bulletins and newspapers:

Looking for Women to Participate in a Psychology Study

The Department of Psychology at Lakehead University is recruiting participants for a Psychology research project that looks at how a woman's relationships and social support relate to her mood and psychological well-being. The researchers would like to hear from as many women as possible who are between the ages of 18 and 45 and living within a heterosexual relationship (marriage, common-law) that is at least one year old. Participants will be entered into three random prize draws of $50. For more information, please contact Jessica at psychologystudy07@gmail.com, or visit http://psychologystudy07.googlepages..com. Our recruitment phase will run until <specific date will be given, depends on when ethics clearance can be obtained>.

Appendix H

Research Questionnaire

RESEARCH QUESTIONAIRE

My 5-digit code is _____

Section A: This section asks for your demographic information. This is for statistical purposes so that we many know the composition of the women in the project. (please print)

1. Age: _____

2. Martial Status: (please tick off one)(for the purpose of the present study only heterosexual relationships can be included)

___ Married — Indicate # of months/ years: _____
___ Common-law — Indicate # of months/ years: _____
___ Intimate relationship — Indicate # of months/ years: _____

3. Number of Children _____

4. Ethnicity (please check)

- Aboriginal (e.g. Inuit, Métis, North American Indian)
- Asian (e.g., Chinese, Japanese, South/East Asian, West Asian)
- Black (e.g., African, Haitian, Jamaican, Somali)
- Latin American/ Hispanic
- White (Caucasian)
- Other: _____

5. Highest Educational Level: _____

6. Your Employment Status (please check all that apply)

- Full-time
- Part-time
- Self-employed /Work at odd jobs
- Student
- Retired
- Homemaker /Stay at home parent
- Not employed
- Disability
- Other (please specify):_____

7. Income (combined household):

- Under $10,000
- Between $10,000 and $25,000
- Between $25,000 and $50,000
- Between $50,000 and $75,000
- Between $75,000 and $100,000
- Over $100,000

8. Place of Permanent Residence (city)_____

9. Within the last 2 weeks, have you been feeling blue, down, or depressed?

YES *NO*

If yes, is it due to a medical condition or medications/supplements that you are taking?

YES *NO*

10. Are you currently receiving treatment for any psychological/psychiatric or major or chronic medical illnesses? *YES* *NO*

If yes please note type and reason for treatment

_____
_____
_____

Section B

INSTRUCTIONS: *{PRIVATE }Compared to how you feel when you are in an even or normal mood state, how would you rate yourself on the following items during the past 2 weeks?*

Please use the following scale

	I have been feeling ...	**1.** Not at all	**2.** Just a little	**3.** More than just a little	**4.** Quite a bit moderately	**5.** Marked or severely
1	down and depressed	1	2	3	4	5
2	less interested in doing things	1	2	3	4	5
3	less interested in sex	1	2	3	4	5
4	less interested in eating	1	2	3	4	5
5	that I've lost some weight	1	2	3	4	5
6	that I can't fall asleep at night	1	2	3	4	5
7	that my sleep is restless	1	2	3	4	5
8	that I wake up too early	1	2	3	4	5
9	heavy in my limbs or aches in back, muscles, or head, more tired than usual	1	2	3	4	5
10	guilty or like a failure	1	2	3	4	5
11	wishing for death or suicidal	1	2	3	4	5
12	tense, irritable, or worried	1	2	3	4	5
13	sure I'm ill or have a disease	1	2	3	4	5
14	that my speech and thought are slow	1	2	3	4	5
15	fidgety, restless, or antsy	1	2	3	4	5
16	that morning is worse than evening	1	2	3	4	5
17	that evening is worse than morning	1	2	3	4	5

Section C

Instructions: *Please circle the number that best describes how you feel about each of the statements listed below, as they relate to your current relationship.*

	1 Strongly Disagree	2 Somewhat Disagree	3 Neither Agree nor Disagree	4 Somewhat Agree	5 Strongly Agree
1. I think it is best to put myself first because no one else will look out for me.	1	2	3	4	5
2. I don't speak my feelings in an intimate relationship when I know they will cause disagreement.	1	2	3	4	5
3. Caring means putting the other person's needs in front of my own.	1	2	3	4	5
4. Considering my needs to be as important as those of the people I love is selfish.	1	2	3	4	5
5. I find it is harder to be myself when I am in a close relationship than when I am on my own.	1	2	3	4	5
6. I tend to judge myself by how I think other people see me.	1	2	3	4	5
7. I feel dissatisfied with myself because I should be able to do all the things people are supposed to be able to do these days.	1	2	3	4	5
8. When my partner's needs and feelings conflict with my own, I always state mine clearly.	1	2	3	4	5
9. In a close relationship, my responsibility is to make the other person happy.	1	2	3	4	5
10. Caring means choosing to do what the other person wants, even when I want to do something different.	1	2	3	4	5
11. In order to feel good about myself, I need to feel independent and self-sufficient.	1	2	3	4	5
12. One of the worst things I can do is to be selfish.	1	2	3	4	5
13. I feel I have to act in a certain way to please my partner.	1	2	3	4	5
14. Instead of risking confrontations in close relationships, I would rather not rock the boat.	1	2	3	4	5
15. I speak my feelings with my partner, even when it leads to problems or disagreements.	1	2	3	4	5

	1 Strongly Disagree	2 Somewhat Disagree	3 Neither Agree nor Disagree	4 Somewhat Agree	5 Strongly Agree
16. Often I look happy enough on the outside, but inwardly I feel angry and rebellious.	1	2	3	4	5
17. In order for my partner to love me, I cannot reveal certain things about myself to him/her.	1	2	3	4	5
18. When my partner's needs or opinions conflict with mine, rather than asserting my own point of view I usually end up agreeing with him/her.	1	2	3	4	5
19. When I am in a close relationship I lose my sense of who I am.	1	2	3	4	5
20. When it looks as though certain of my needs can't be met in a relationship, I usually realize that they weren't very important anyway.	1	2	3	4	5
21. My partner loves and appreciates me for who I am.	1	2	3	4	5
22. Doing things just for myself is selfish.	1	2	3	4	5
23. When I make decisions, other people's thoughts and opinions influence me more than my own thoughts and opinions.	1	2	3	4	5
24. I rarely express my anger at those close to me.	1	2	3	4	5
25. I feel that my partner does not know my real self.	1	2	3	4	5
26. I think it's better to keep my feelings to myself when they do conflict with my partner's.	1	2	3	4	5
27. I often feel responsible for other people's feelings.	1	2	3	4	5
28. I find it hard to know what I think and feel because I spend a lot of time thinking about how other people are feeling.	1	2	3	4	5
29. In a close relationship I don't usually care what we do, as long as the other person is happy.	1	2	3	4	5
30. I try to bury my feelings when I think they will cause trouble in my close relationship(s).	1	2	3	4	5
*31. I never seem to measure up to the standards I set for myself.	1	2	3	4	5

* If you answered the last question with a 4 or 5, please list up to three standards you feel you don't measure up to.

1. 2.

3.

Section D Part 1

People help each other out in a lot of different ways. Suppose you had some kind of problem (were upset about something, needed help with a practical problem, were broke, or needed some advice or guidance), how likely would *(a) members of your family (b) your friends and (c) your partner* be to help you out in each of the specific ways listed below.

We realize you may rarely need this kind of help, but if you did would family, friends and your partner help in the ways indicated. Try to base your answers on your past experience with these people.
Use the scale below, and circle one number under family, one under friends, and one under partner in each row.

1- no one would do this
2 - someone might do this
3- some family member/friend would probably do this
4 - some family member/friend would certainly do this
5- most family members/friends would certainly do this

Items	(a) family	(b) friends	(c) partner
1. Would suggest doing something, just to take my mind off my problems	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
2. Would visit with me, or invite me over	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
3. Would comfort me if I was upset	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
4. Would give me a ride if I needed one	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
5. Would have lunch or dinner with me	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
6. Would look after my belongings (house, pets, etc.) for a while	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
7. Would loan me a car if I needed one	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
8. Would joke around or suggest doing something to cheer me up	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
9. Would go to a movie or concert with me	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
10. Would suggest how I could find out more about a situation	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
11. Would help me out with a move or other big chore	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
12. Would listen if I needed to talk about my feelings	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
13. Would have a good time with me	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
14. Would pay for my lunch if I was broke	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
15. Would suggest a way I might do something	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
16. Would give me encouragement to do something difficult	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
17. Would give me advice about what to do	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
18. Would chat with me	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

1- no one would do this
2 - someone might do this
3- some family member/friend would probably do this
4 - some family member/friend would certainly do this
5- most family members/friends would certainly do this

Items	(a) family	(b) friends	(c) partner
19. Would help me figure out what I wanted to do	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
20. Would show me that they understood how I was feeling	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
21. Would buy me a drink if I was short of money	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
22. Would help me decide what to do	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
23. Would give me a hug, or otherwise show me I was cared about	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
24. Would call me just to see how I was doing	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
25. Would help me figure out what was going on	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
26. Would help me out with some necessary purchase	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
27. Would not pass judgment on me	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
28. Would tell me who to talk to for help	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
29. Would loan me money for an indefinite period	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
30. Would be sympathetic if I was upset	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
31. Would stick by me in a crunch	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
32. Would buy me clothes if I was short of money	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
33. Would tell me about the available choices and options	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
34. Would loan me tools, equipment, or appliances if I needed them	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
35. Would give me reasons why I should or should not do something	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
36. Would show affection for me	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
37. Would show me how to do something I didn't know how to do	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
38. Would bring me little presents of things I needed	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
39. Would tell me the best way to get something done	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
40. Would talk to other people, to arrange something for me	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
41. Would loan me money and want to "forget about it	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
42. Would tell me what to do	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
43. Would offer me a place to stay for awhile	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
44. Would help me think about a problem	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
45. Would loan me a fairly large sum of money (say the equivalent of a month's rent or mortgage	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Section D Part 2

The following questions ask you how satisfied you are with the OVERALL support you receive from *(a) members of your family (b) your friends and (c) your partner* in a number of specific areas. Please rate your degree of satisfaction from

1 Very Dissatisfied	2 Fairly Dissatisfied	3 A little Dissatisfied	4 A little Satisfied	5 Fairly Satisfied	6 Very Satisfied

Items	(a) family	(b) friends	(c) partner
1. Emotional Support *Examples: comforted me when I was upset/ listened when I needed to talk about my feelings*	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6
2. Socialization *Examples: went to a movie or concert with me/ call me just to see how I was doing*	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6
3. Practical Assistance *Examples: gave me a ride when I needed one/ helped me out with a move or other big chore*	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6
4. Financial Assistance *Examples: paid for my lunch when I was broke/ loaned me money for an indefinite period of time*	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6
5. Advice/ Guidance *Examples: told me who to talk to for help/ helped me think about a problem*	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6

Section E

Instructions: Using the following scale, circle the number that best describes the degree of satisfaction you feel in various areas of your relationship.

	1 *Very strongly disagree*	**2** *Strongly disagree*	**3** *Disagree*	**4** *Neither disagree nor agree*	**5** *Agree*	**6** *Strongly Agree*	**7** *Very strongly agree*
1. We have a good relationship	1	2	3	4	5	6	7
2. My relationship with my partner is very stable	1	2	3	4	5	6	7
3. My relationship with my partner is strong	1	2	3	4	5	6	7
4. My relationship with my partner makes me happy	1	2	3	4	5	6	7
5. I really feel like part of a team with my partner	1	2	3	4	5	6	7

6. All things considered, what degree of happiness best describes your relationship? (please indicate the degree on the scale below)

Unhappy Happy Perfectly Happy

1 2 3 4 5 6 7 8 9 10

Appendix I

Part 1 Cover Letter for Research Questionnaire - for online and hardcopy versions

Part 1 Research Questionnaire – Introduction to the Study

Information on Study

- This Study, *Women, Intimate Relationships and Social Support*, will be investigating how women's perceptions and behaviours within their intimate and social relationships relate to mood.

- As a participant in the study you will be asked to complete a questionnaire that will ask about your relationships, your feelings, thoughts and behaviours. Please complete the pages in the order in which they are presented. This should take approximately 30-40 minutes of your time.

- If you are using the web-link to complete the survey you will be asked to submit your answers electronically upon completion of the items. If you are using the paper form, please return all the completed forms to one of the designated safe spots
  - *-At Lakehead University: leave it in the collection box marked "Women, Relationships and Social Support" located in SN1042A right outside the Psychology main office*

- Your participation is completely voluntary. Please note that there is no risk or benefit to you for completing the questionnaire. In return for your involvement, we will enter you into three $50 random prize draws upon return of your questionnaire.

- Your responses will be kept confidential and identified only by a number code. Print copies of the questionnaires will be kept in a secure confidential storage at Dr. Josephine Tan's lab for 7 years as required by the ethics guidelines of Lakehead University, after which time they will be destroyed. All data that is transmitted electronically is done so through the Survey Monkey service which uses SSL encryption to protect confidential information during transmission (a similar service that is used by online banking). The data collected through Survey Monkey will be downloaded for use by the researchers and then stored with the print data. The electronic data that is being held securely through Survey Monkey will then be permanently deleted from the server.

- If you feel unsure about using the electronic format we would be happy to provide a traditional print copy of the survey for you.

- If you wish to have a summary of the study when it is completed, just fill in the bottom section of the consent form in the questionnaire.

- We have a Part 2 to this study for a subgroup of people who respond to this questionnaire and who are interested in going further in this project. Part 2 involves a focus group discussion among a small group of women to share their views on the importance of receiving emotional support and practical assistance from different sources and how it can influence mood and their relationships. *You are under no obligation to participate in the second part of the study and it will not affect your participation in this questionnaire in any way.* The discussions in the focus groups are voluntary and confidential, and only first or false names will be used. To help us keep track of the information, the discussions will be audiotaped and transcribed. All real names and identifying information will be removed. Those who participate in the second part of the study will have their names entered for an additional two $25 random prize draws.

If you have any questions, please feel free to contact the researcher and the project supervisor at any time. Thank you.

Jessica Johnson, HBA
Graduate Student in
MA Clinical Psychology with
Specialization in Women's Studies
Psychology Dept.
Lakehead University
Email: psychologystudy07@gmail.com
Tel: to be determined

Dr. Josephine Tan, C. Psych.
Project Supervisor
Associate Professor
Psychology Dept
Lakehead University
Email: jtan@lakeheadu.ca
Tel: 807-346-7751

Appendix J

Part 1 Consent Form - for hard copy version and online version of the Research Questionnaire

PART 1 CONSENT FORM TO PARTICIPATE IN RESEARCH (hard copy format)

Study Title: *Women, Intimate Relationships and Social Support*

Researcher: *Jessica Johnson*

Project Supervisor: *Dr. Josephine Tan*

Purpose

- I have been informed that the purpose of the research is to investigate the effects of women's social support and relationship involvement on their moods within their intimate relationships.

Procedures

- I will be asked to fill out a research questionnaire. It is anticipated that completion of the items should take 30 to 40 minutes.
- My responses to the questionnaire will be completely confidential.
- My participation is voluntary and I am free without penalty to withdraw from the study or refrain from answering any questions that I do not wish to answer.
- There is no foreseeable risk or benefit for filling out the questionnaire.
- If I indicate my interest below in participating in Part 2 of the study, the researcher may invite me back to participate in follow up discussion groups. I am in no way obligated to participate in the follow up and it will in no way affect my participation in the questionnaire.
- For my completing the questionnaire, my name will be entered into a random draw for three $50 prizes.
- All data collected will be stored in secure confidential storage at Dr. Josephine Tan's lab for 7 years as required by the guidelines of Lakehead University, after which time they will be destroyed.

By signing below, I indicate that I have carefully studied the above information and understand this agreement. I freely consent and voluntarily agree to participate in this study. I am 18 years of age or older.

Name of Participant (please print):_____

Signature: _____ ***Date:*** _____

We are very interested in having some people return for Part 2 of the study where they can give us their views on social support. Participants can say as much or as little as they like. Only first names or false names will be used. The discussion will be kept confidential, audiotaped and transcribed to help us sort through the information. The transcribed data will not contain any real names or any identifying information to protect participants' anonymity. Data obtained from the group discussions will be summarized at the group level, not at the individual level. All participants will be entered into two $25 random prize draws.

Would you be interested in being contacted for this? ***YES*** ***NO***

If you are interested in participating Part 2 of the study please create a personal number code below. You will be asked enter this code at the top of the Research Questionnaire. Your name and your answers can only be connected by the researchers through this code. This way your answers and your personal information will remain separate.

If you are interested in joining us for Part 2, please proceed to set up your 5 digit personal code.

How to create your 5 digit personal code:

1. What is the first letter of your mother's name?
2. What is use the first letter of your first name?
3. What is the first letter in the name of your high school?
4. Please pick a random number you will remember between 10 and 99

Please write down your code _____
You will be asked to provide it at the top of the Research Questionnaire.
If you are interested in participating in Part 2 and have created your 5 digit code, please provide a telephone number or email by which we can contact you for the second part:

Please also provide your mailing address below:

.....

Additional Information

- How may we contact you if you are a winner in our random prize draws for completing the Research Questionnaire? This will take place in the summer of 2008.

  Name: _____

  Tel or Email: _____

- Results from this study based on the Research Questionnaire should be ready by the winter of 2008. If you are interested in receiving a copy of the summary of the results, please provide us with your complete postal address below for the winter of 2008:

***please return this information with your consent form and questionnaire to the researcher ***

PART 1 CONSENT FORM TO PARTICIPATE IN RESEARCH (electronic format)

Study Title: *Women, Intimate Relationships and Social Support*

Researcher: *Jessica Johnson*

Project Supervisor: *Dr. Josephine Tan*

Purpose

- I have been informed that the purpose of the research is to investigate the effects of women's social support and relationship involvement on their moods within their intimate relationships.

Procedures

- I will be asked to fill out a research questionnaire online. It is anticipated that completion of the items should take 30 to 40 minutes.
- My responses to the questionnaire will be completely confidential.
- My participation is voluntary and I am free to withdraw from the study or refrain from answering any questions that I do not wish to answer.
- There is no foreseeable risk or benefit for filling out the questionnaire.
- By indicating my interest below the researchers may invite me back to participate in follow up discussion groups. I am in no way obligated to participate in the follow up and it will in no way affect my participation in the questionnaire.
- For my completing the questionnaire, my name will be entered into a random draw for three $50 prizes.
- All print data will be stored in secure confidential storage at Dr. Josephine Tan's lab for 7 years as required by the guidelines of Lakehead University, after which time they will be destroyed. The data collected through Survey Monkey will be downloaded for use by the researchers and then stored with the print data. The electronic data, that is being held securely through Survey Monkey, will then be permanently deleted from the server.

By clicking YES below, I indicate that I have carefully studied the above information and understand this agreement. I freely consent and voluntarily agree to participate in this study. I am 18 years of age or older.

► Yes, I agree to participate ► No, I do not agree to participate

---

The following information will appear after the survey in order that the personal information and responses in electronic format remain separate.

We are very interested in having some people return for Part 2 of the study where they can give us their views on social support. Participants can say as much or as little as they like. Only first names or false names will be used. The discussion will be kept confidential, audiotaped and transcribed to help us sort through the information. The transcribed data will not contain any real names or any identifying information to protect participants' anonymity. Data obtained from the

group discussions will be summarized at the group level, not at the individual level. All participants will be entered into two $25 random prize draws.
You are under no obligation to participate in the second part of the study and it will not affect your participation in the questionnaire in anyway*

If you are interested in participating Part 2 of the study please create a personal number code below. You will be asked enter this code in a separate section that is to follow. Your name and your answers can only be connected by the researchers through this code. This way your answers and your personal information will remain separate. *If you are not interested in participating in the second part please skip this step and exit at this point. Once you exit, you will not be able to return to create a personal number code.*

If you are interested in joining us for Part 2, please proceed to set up your 5 digit personal code.

How to create your 5 digit personal code:

1. What is the first letter of your mother's name?
2. What is use the first letter of your first name?
3. What is the first letter in the name of your high school?
4. Please pick a random number you will remember between 10 and 99

Please write down your code because you will be asked to provide it in the next step in a separate section.

If you would like to be entered into our random draw for three $50 prizes please provide us with your contact information below.

Draws to take place in the summer of 2008.
Name:
Email Address:
Telephone:

If you are interested in joining us for Part 2 of the study, and had created the personal five digit code, please complete the section below. It will ask you for your personal code.

I am interested in being contacted about the second part of the study
Name:
Personal Code:
Email Address:
Postal Address:
Telephone:

Results from this study based on the Research Questionnaire should be ready by the winter of 2008. If you are interested in receiving a copy of the summary of the results, please provide us with your complete postal address below for the winter of 2008:

_____

_____

Appendix K

Debriefing Information for Research Questionnaire – for online and hard copy formats

Debriefing Form

Please do not read this page if you are not yet done with the questionnaire. If you wish to change any of your answers or you need to complete some sections in the questionnaire, please go back now and do that. If you have fully completed filling out your questionnaire and it is ready to be sent out to us, then please read this Debriefing Page.

This Debriefing will provide you with more detailed information about this project. We were not able to do that at the beginning because we did not wish to influence your answers. That is why we had to make sure that you are now completely done with the questionnaire before you continue on with the Debriefing.

This project, as you already know, looks at how social support and relationships are linked to a woman's moods and psychological well-being. In particular we want to examine a relationship communication style known as "self-silencing". Self-silencing can involve keeping thoughts and feelings to yourself, frequently sacrificing or putting your own needs last to maintain harmony in your relationships, censoring your voice and repressing anger. It is believed that high self-silencing affects psychological distress in women.

You just completed Part 1 of the study. In this Part 1, we are interested in different types of social support such as emotional support, practical assistance, financial assistance, socializing, and guidance and advice. We are also interested in the types of social support systems that include family, friends and intimate partner. Our research questions bear on how the amount of the different types of support, and satisfaction with the support received, from different sources relate to a women's psychological well-being and her self-silencing.

We also have a Part 2 to this study. In Part 2, we will be inviting women with a range of scores on the assessment measures to join a focus group discussion. We want to hear from them how they view their social support system and any positive or negative ways they feel it affects their feelings, moods, and behaviours, and how they communicate within relationships. The groups will help us to contextualize our findings from the Research Questionnaire. We will be able to know the meaning of social support for women in their everyday lives. Of course, the

responses from the groups will be kept confidential and nothing can be traced back to anyone. We will be using codes rather than real names in our data collection.

We do not really know what we will find. However, the results from both stages of this study will enable us to understand important ways social support can affect self-silencing and depression. The results will have implications for helping women who are at risk for depression.

At this point, if you choose to be involved in Part 2 of this study when you had initially decided not to, please feel free to go back to the Consent Form and make the change. Your assistance is greatly appreciated.

Thank you very much for your help in this project. We look forward to receiving your questionnaire.

Sincerely,
Jessica Johnson, HBA

NOTE:

This marks the end of the Research Questionnaire. Thank you very much for participating in this part of the project. Please return the whole package in the envelope provided as soon as possible to one of the designated secure drop points, or mail it directly back to the researcher at Jessica Johnson, c/o Lakehead University Department of Psychology SN 1042, 955 Oliver Road, Thunder Bay, ON P7B 5E1, as soon as possible. The secure drop points are listed below:

(*if online form will just ask for participants to click "Send"*)

THERAPY/ COUNSELLING RESOURCES AVAILABLE IN THUNDER BAY

If you or anyone you know would like access to mental health services below are some resources that do not require a physician's referral:

- Lakehead University Health and Counselling Centre: 343-8361 (for students only)
- Confederation College Counselling Services: 475-6112 or 1-800-465-5493 (toll free in region) (for students only)
- Thunder Bay Counselling Centre: 684-1880 or http://www.tbaycounselling.com/
- Catholic Family Development Centre: 345-7323
- Lutheran Community Care Centre: 345-6062 or 346-7597 (counselling service line) or http://www.lccctbay.org/
- Beendigen: 622-1121 or http://www.beendigen.com/
- Thunder Bay Sexual Abuse/ Sexual Assault Counselling and Crisis Centre: 345-0894 (main) 344-4502 (crisis line) or http://www.tbsasa.org/
- Thunder Bay Crisis Response: 346-8282

Other Resources

- Canadian Mental Health Association: 345-5564
- Employee Assistance Programme (available in many companies – please speak to your Human Resources department)
- Private practitioners listed in the yellow pages of your phone directory under: Marriage, Family & Individual Counsellors *or* Psychologists & Psychological Associates *or* Psychotherapy *or* Stress Management and Counselling

Please keep this page for your files.

(online respondents will be asked to right click this page and select print to obtain a copy for their records)

Jessica Johnson, HBA
Graduate Student in
MA Clinical Psychology with
Specialization in Women's Studies
Psychology Dept.
Lakehead University
Email: psychologystudy07@gmail.com
Tel: 343-8168

Dr. Josephine Tan, C. Psych.
Project Supervisor
Associate Professor
Psychology Dept
Lakehead University
Email: jtan@lakeheadu.ca
Tel: 807-346-7751

Appendix L

Thank-you Letter to Women Who Completed Part 1 But Did Not Agree to Participate in Part 2

*on Lakehead University Letterhead** **PRINT COPY**

Date:

Name:
Address:

Dear _____ (name)

Recently, you completed a Research Questionnaire for our psychology projected entitled *Women, Intimate Relationships and Social Support.* We have received your survey and would like to express our very heartfelt thanks to you for taking part. Your responses will be kept confidential. You will also be entered into three $50 prize draws that will take place in the summer of this year. You will be notified if you are a winner. We will also send out a summary of the results of the study if you have requested it. If you did not make such a request at the time of the survey but would like a copy of the results please contact us at psychologystudy07@gmail.com. These should be ready in the winter of 2008.

Once again, thank you very much for your involvement in our project. Without volunteers like you, advancement in theory and research would not be possible. If you have any questions, please do not hesitate to contact us.

Sincerely,

Jessica Johnson, HBA
Graduate Student in
MA Clinical Psychology with
Specialization in Women's Studies
Psychology Dept.
Lakehead University
Email: psychologystudy07@gmail.com
Tel: 343-8168

Dr. Josephine Tan, C. Psych.
Project Supervisor
Associate Professor
Psychology Dept
Lakehead University
Email: jtan@lakeheadu.ca
Tel: 807-346-7751

ELECTRONIC COPY

Dear _____ (name)

Recently, you completed a Research Questionnaire for our psychology projected entitled *Women, Intimate Relationships and Social Support.* We have received your survey and would like to express our very heartfelt thanks to you for taking part.

We would like to remind you that your responses will be kept confidential. You will also be entered into three $50 prize draws that will take place in the summer of this year. You will be notified if you are a winner.

We will also send out a summary of the results of the study if you have requested it. If you did not make such a request at the time of the survey but would like a copy of the results please contact us at psychologystudy07@gmail.com. These should be ready in the winter of 2008.

Once again, thank you very much for your involvement in our project. Without volunteers like you, advancement in theory and research would not be possible. If you have any questions, please do not hesitate to contact us.

Sincerely,

Jessica Johnson, HBA
Graduate Student in
MA Clinical Psychology with
Specialization in Women's Studies
Psychology Dept.
Lakehead University
Email: psychologystudy07@gmail.com
Tel: 343-8168

Dr. Josephine Tan, C. Psych.
Project Supervisor
Associate Professor
Psychology Dept
Lakehead University
Email: jtan@lakeheadu.ca
Tel: 807-346-7751

Appendix M

Information to be Provided During Telephone Contact for the Focus Group

Information to be Provided During Telephone Contact for Focus Groups

- Give name, organization and title of study (Jessica Johnson, Dept Psychology at Lakehead University, Women, Intimate Relationships and Social Support
- Thank them for participating in first part
- Mention they had indicated they would be interested in participating in the second part of the study and that you were calling to see if they would still be interested in volunteering at this time to participate in one of the focus groups.
- Provide them with specific information about the focus groups including:
    - The purpose of the groups is to add a depth of meaning by contextualizing the information from the first section and is very important to the study. Therefore, all their comments and opinions are valuable and therefore extremely important to the study.
    - The focus groups will consist of 4 to 8 women and the facilitator. A variety of women have been chosen to participate based on the information given in the questionnaire. A mixture of women has been selected based on their responses.
    - Each session will run about 90 minutes. The session will be, with everyone's consent, audiotaped and then transcribed for use by the researchers. In the transcription all identifying information will be removed. The tape will be kept in secure confidential storage for 7 years in Dr.Tan's lab in the Psychology Department at Lakehead University and then destroyed.
    - Participants will be asked to respect other people's confidentiality as well as know that their own will be respected in the study process.
    - Participation is voluntary and is no risk or benefit for you to taking part in this group.

- For a taking part in this phase of the study their name will be entered into an additional 2 $25 random prize draws.

- Ask them if they have any additional questions at this time.
- If they would still like to participate, arrange a date and time for them (as well give location, directions etc)
- Provide them again with the contact information for the project and the researcher in case they have any other questions.

Appendix N

Information to be Provided by Email Contact for the Focus Group

Email Contact Outline for Focus Groups

Hello_____(name)

My name is Jessica and I am a Master's student in Clinical Psychology here at Lakehead University. I am emailing you in relation to your recent participation in the study "Social Support, Intimate Relationships and Mood". Thank you for putting in your questionnaire. We are now proceeding with the second part of this study. You indicated interest in participating in this second phase.

Here is some information about the second part of the study,

- This part will involve participating in a small discussion group of 4 to 8 women, plus myself as facilitator. A mixture of women has been chosen, based on their responses to the questionnaire, to participate in these sessions. The session should run for about 90 minutes.
- The purpose of the focus group is to add depth of meaning by contextualizing the information from the research questionnaire. Your opinions are important and we value your comments.
- Participants will be asked to respect the confidentiality of other participants by not sharing with people outside of the group any aspect of the discussion.
- The discussion will be audio-taped to allow us to keep track of the information, and then transcribed for the purpose of analysis.
- All names identifying information will be removed from the transcriptions to protect the privacy of the focus group participants.
- The tape will be kept in secure confidential storage for 7 years in Dr.Tan's lab in the Psychology Department at Lakehead University and then destroyed.
- Your participation is voluntary which means that you have the option of not joining us for the second part of the study. However, we hope that you do because we would like to hear from as many participants as possible.
- There is no risk or benefit for you to taking part in this group discussion.
- Also, for a taking part in this phase of the study you name will be entered into an additional two $25 random prize draws.

I am writing to let you know that we have 2 pre-scheduled focus groups for these days and times:

Group 1: Day = XXXXX, Time = XXXX, Location = XXXXX
Group 2: Day = XXXXX, Time = XXXX, Location = XXXXX

Would you be able to make it to one of the 2 groups above? If not, when would be a good day/time for you?

Of course, you are under no obligation to continue with the focus group part of the project if you have changed your mind. Just let us know. We do need as many people as possible to obtain a representative view and hope that you continue to have an interest in the group discussion.

If you have any question, please feel free to contact me (Jessica) at psychologystudy07@gmail.com or TEL #.

Thank you for your help.

Jessica Johnson, HBA
MA student in Clinical Psychology with specialization in Women's Studies

Appendix O

Thank-you Letter to Women Who Agreed to Participate in Part 2, but Were Not Selected for Focus Groups

*on Lakehead University Letterhead**

Date:

Name:
Address:

Dear _____ (name)

Recently, you completed a Research Questionnaire for our psychology projected entitled *Women, Intimate Relationships and Social Support.* We have received your survey and would like to express our very heartfelt thanks to you for taking part. Your responses will be kept confidential. You will also be entered into three $50 prize draws that will take place in the summer of this year. You will be notified if you are a winner. We will also send out a summary of the results of the study if you have requested it. These should be ready in the winter of 2008.

You also indicated on your consent form that you are interested in being part of the second phase of this study where there will be group discussion on communication and social support. We had a strong response from the participants during phase one and consequently we are unable to accommodate everyone. We regret having to inform you that we will not be able to schedule you into a group. However, your answers to the survey will be very valuable in helping us understanding the social and intimate relationships of women.

Thank you very much for your involvement in our project. Without volunteers like you, advancement in theory and research would not be possible. If you have any questions, please do not hesitate to contact us.

Sincerely,

Jessica Johnson, HBA
Graduate Student in
MA Clinical Psychology with
Specialization in Women's Studies
Psychology Dept.
Lakehead University
Email: psychologystudy07@gmail.com
Tel: 343-8168

Dr. Josephine Tan, C. Psych.
Project Supervisor
Associate Professor
Psychology Dept
Lakehead University
Email: jtan@lakeheadu.ca
Tel: 807-346-7751

Appendix P

Cover Letter for Focus Groups

Information Sheet for Focus Group Participants (two pages)
(to be read prior to the commencement of the focus group discussions)

Study

You are here to participate in this focus group, which is the second phase of this Lakehead University Psychology research study on *Women, Intimate Relationships and Social Support*. The function of these focus groups is to explore women's lived experiences of social support and communication in their relationships. We greatly appreciate your willingness to participate.

You completed the survey that comprised the first part of the study. Based upon your responses in that questionnaire, you have been selected for this second phase of the study because you meet the selection criteria for our focus groups. Through these discussion groups, we want to further understand the role of social support in women's lives and how it interacts with their communication style and their mood.

The purpose of the focus groups is to discuss any added meanings of your answers in the questionnaire in phase 1 that could help us contextualize or enrich the information. This discussion meeting will take approximately 90 minutes. I, Jessica Johnson, the principal researcher for this study, will guide the process as the facilitator.

The discussion groups will follow a semi-structured format. This will involve discussing some predetermined questions but will leave the session open to exploring other areas and themes that arise in conversation. This allows the focus groups to be a "collaborative process of inquiry".

Your participation in this part of the project is completely voluntary. Everybody's right to privacy and confidentiality has to be respected. What this means is that nothing that is discussed here can be shared with people outside of the group. We will use only first names or false names. You are free to respond or not respond to any questions, or to leave if you desire to do so. However, all your comments and opinions are valuable to us and therefore extremely important to this study.

The discussion will be audiotaped so that we don't miss any information. Only I and the project supervisor, Dr. Josephine Tan, will have access to the audiotape. The discussion from the audiotape will be transcribed and all real names and identifying information will be removed or changed to protect people's privacy. The information derived from the discussion will be coded and analyzed for common themes in the topic.

All the data that we collect in this project will be kept in secure storage at Dr. Tan's lab for a period of 7 years, after which it will be destroyed. The results will be presented in an aggregate format or under the disguise of a pseudonym (i.e. Person 1, Person 2) so that responses cannot be tracked back to any particular individual.

Attached to this form is a listing of resources in Thunder Bay for your information. The researcher will also be available after the focus group to discuss these listings and related concerns.

As a token of our appreciation for your participation your name will be entered into 2 draws of $25. These draws will take place after all the groups have met.

Lastly, we would be happy to send you a summary of the report when the study is complete. Please indicate on the attached consent form if you would like to receive this summary.

Thank you

Therapy/ Counselling Resources Available in Thunder Bay

(please keep this page for your files)

If you or anyone you know would like access to mental health services below are some resources that do not require a physician's referral:

- Lakehead University Health and Counselling Centre: 343-8361 (for students only)
- Confederation College Counselling Services: 475-6112 or 1-800-465-5493 (toll free in region) (for students only)
- Thunder Bay Counselling Centre: 684-1880 or http://www.tbaycounselling.com/
- Catholic Family Development Centre: 345-7323
- Lutheran Community Care Centre: 345-6062 or 346-7597 (counselling service line) or http://www.lccctbay.org/
- Beendigen: 622-1121 or http://www.beendigen.com/
- Thunder Bay Sexual Abuse/ Sexual Assault Counselling and Crisis Centre: 345-0894 (main) 344-4502 (crisis line) or http://www.tbsasa.org/
- Thunder Bay Crisis Response: 346-8282

Other Resources

- Canadian Mental Health Association: 345-5564
- Employee Assistance Programme (available in many companies – please speak to your Human Resources department)
- Private practitioners listed in the yellow pages of your phone directory under: Marriage, Family & Individual Counsellors *or* Psychologists & Psychological Associates *or* Psychotherapy *or* Stress Management and Counselling

If you have any other questions about these resources or would like more information on the topics discussed today please feel free to contact myself or Dr. Tan for more information. Thank you.

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Appendix Q

Part 2 Consent Form – for focus groups

PART 2 CONSENT FORM

Study Title: Women, Intimate Relationships and Mood, Phase 2.

Researcher: Jessica Johnson

Project Supervisor: Dr. Josephine Tan

Purpose: I have been informed that the purpose of this study is to explore women's lived experiences of social support and communication in their relationships.

Procedure:

- I will be asked to take part in a 90 minute discussion group. I am able to choose to participate to the extent of my own personal comfort level. This includes saying as much or as little as I am comfortable with, declining to answer questions if I so choose, or to leave if I wish.
- I understand that the discussion group will be audio taped so that the researchers will not miss information I also understand that the tape will be transcribed for further analysis by the researchers. I understand that all identifying information will be removed from the transcriptions.
- My answers will be kept confidential and I will not be identified by name in any ensuing thesis, reports or publications. Instead all participants will be given a code number such as person 1, person 2 etc.
- I will respect the confidentiality and rights of the other participants and, in turn, I can expect similar respect. This includes not discussing anything from inside the group with others outside the group.
- My participation is strictly voluntary and I am free to withdraw if I so choose. However, confidentiality within and outside of the group still has to be maintained
- There is no direct benefit to me for participating in this study. While there are no risks associated with participating in the focus group, there may be some topics of discussion which can be uncomfortable for me and I have the right to decline to answer these questions.

- All information provided will be held in confidence by the researchers and kept in secure storage in Dr. Tan's (project supervisor) lab in the Psychology Department at Lakehead University for a period of seven years after which time it will be destroyed.
- For participating in this focus group, I will be entered into 2 random draws of $25 prizes.

By signing below, I signify that I have carefully studied and understood the above information and freely give my consent for participation in the study. I am 18 years of age or older.

Participant Name (please print): _____

Participant Signature: _____

Date: _____

**if you wish to receive a summary of the results upon the completion of the study, please print your mailing address below*:

Appendix R

Facilitators Guide for Focus Groups

Focus Group Research

Facilitator's Guide

- As the women arrive they will be given a cover letter to read and will be given a chance to ask any questions they might still have. The women will also be given a copy of the resource list from part one.
- The general consent agreeing to participate and be audio-taped will be distributed for signing.
- When all the women have signed the consent form, the formal discussion can begin.
- The women will be asked to sit around a large table. The facilitator will introduce herself and welcome the women and thank them for participating.
- They will be reminded orally of the following information
- They will be told that some of the material being covered may be quite personal in nature, so it is essential that each person also promise to honour the confidentiality of everything that is discussed and to treat each other with respect. This would mean that disclosures and discussions in this session are not to be shared with anyone outside of the group. Nevertheless, it is hoped that everyone will be comfortable in being candid and open.
- They will also be told that there are no right or wrong answers and to please be comfortable speaking up if their views differ or if their situation is not being addressed.
- They will be asked to only identify themselves by their first name and reminded that any quotations used will be given a code name.
- They will also be informed that, should any of the material that is discussed today give rise to personal issues that may of concern to them, there are many psychological health resources available in Thunder Bay. As well, the women will be told that the facilitator will be happy to talk to individuals afterward about these resources and give suggestions for referral to these health sources.
- The audio tape will be switched on.
- The focus group session will start with roundtable introductions, where the women will be asked to tell the group her first name and one of her interests or favourite hobbies (to open discussion and relax participants).
- The facilitator will then begin the discussion by posing a number of open-ended questions to the group.

Focus Questions

- *Focus on aspects of Self-Silencing*
  - When are they reluctant to share thoughts and feeling with certain people?
  - Would they like to share more with their partner or others and what stops you from doing so?

- *Focus on aspects of Social Support*

- What is the importance of emotional support and practical assistance received from different sources?
- In what situations would they seek the support of friends, family and partner?
- What meanings do they ascribe to their receiving or not receiving sufficient emotional and instrumental support from their partner and from their friends?

➢ *Focus on aspects of Depressed Mood*

- How do they deal with insufficient emotional or instrumental support from their partner and/or friends?
- How does receiving/ not receiving support change their mood or influence depressive symptoms?
- How does support from others empower them as an individual and within their relationships?

- As the session progresses it is likely that the discussion will branch off into other related areas of focus that are important to the women but were not necessarily preconceived by the researcher. This will be welcomed and the topics explored. Nevertheless, the facilitator will also be monitoring the conversation in order that the discussion does not get off topic.
- The facilitator will also watch that each woman is given a fair and adequate chance to speak in turn, but will respect any individual who wishes to minimize her participation.
- At approximately the forty-five minute mark (depending on the flow of conversation) the women will be given the chance to have a five minute break.
- At the eighty minute mark the women will be informed that the session has come to the last ten minutes and the discussion will be wrapped up. (if the conversation is dwindling any time before the eighty minute mark the session can be wrapped up)
- As the conversation comes to an end at the ninety minute mark, the facilitator will, once again, thank the women for participating and will then shut off the audio-tape.
- Following the session the facilitator will remain behind to speak to anyone that has questions about accessing the resources, the research project, self-silencing etc.