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Depression and self-silencing in lesbian and heterosexual women

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Depression and self-silencing in lesbian and heterosexual women.

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Abstract

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Depression among lesbians is an underexplored area in the literature of the psychology of women and in depression research. A few investigators have hypothesized about the factors that place lesbians at risk for depression, and have explored those hypotheses experimentally. However, there is a large gap in the understanding of lesbians and depression. Dana Jack (1991) proposed a model of depression which holds that women who fail to represent their experiences to romantic partners are at increased risk for depression. One hundred and seventy participants were recruited to test this model was tested (85 lesbians and 71 heterosexual women, as well as 14 bisexual women who were included in the demographics but otherwise excluded) using Jack's Silencing the Self Scale, the Beck Depression Inventory, and a demographic questionnaire. Lesbians were also asked to complete Cass' Stage Allocation Measure. An additional 11 subjects failed to complete the BDI and so were excluded from all analyses involving that test. It was found that the lesbian sample was more self-silenced than the heterosexual group, but there was no difference in the level of depression between groups. A three-way ANOVA revealed significant differences between stage of coming out and self-silencing as well as stage of coming out and depression. Several explanations were offered for the unexpected finding of increased self-silencing among lesbians. Further research is needed to better elucidate self-silencing in lesbians, as well as the experience of depression in lesbians.

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Chapter 1

Introduction

> And suddenly I felt so sick to death of my own silence that I needed to speak too. It wasn't that there was something in particular I was burning to say. I didn't even know what it would be. I just needed to open my throat for once and hear my own voice. And I was afraid if I let this moment pass, I might never be brave enough to try again (p 296).
>
> - Leslie Feinberg (1993) Stone Butch Blues

The word "silence," while having essentially one definition, has differing connotations. Conventional wisdom generally holds that silence is a virtue, even holy. The type of silence that is the subject of this study is not virtuous or holy silence. It is not the type of silence that is affirming, and is associated with wisdom – this silence is a kind of self-expression. Rather, the silence addressed here is a profound failure to express oneself and an awesome disconnection from the self. This silence is so dangerous that it can be life-threatening.

This treacherous type of silence is a nodal point of study by some researchers interested in women's development and women's experience of depression. This movement in psychology has attempted over the past twenty years or so to document women's development using women's language and terminology. This group of researchers has been reacting to decades of psychological theory that does not address women's development as different from men's at all, or if it does, it does so in very pathological language. Women, especially depressed women, from Freud onward, have been called dependent, and their capability for mature relationships has been repeatedly been called into question. In contrast, these more recent theorists have described

women's development from women's point of view – that is, refusing to adopt male development as the standard against which women's behavior should be measured.

Dana Jack, one researcher from this group, has focused on silence in women and it's relationship to depression. This silence is failing to say what one knows to be true, from fear of being wrong, or being criticized, or causing conflict. It is failing to say what one needs, from fear of being labeled demanding or "selfish". It is believing that doing for the other often does, and perhaps *should*, come at the expense of self. It is believing that relatedness cannot occur if one insists on one's experience. This way of silence, that begins in a conscious suppression of one's experience, ends in an inability of the individual to relate her experience and to know what she needs. Jack (1991) found women who engage in this type of silence to be at grave risk. She labeled this phenomenon "silencing the self."

Silence is also a powerful issue in the lives of lesbians and gay men. Silence=Death is one of the most pervasive slogans of lesbian and gay rights activists. In Stone Butch Blues (1993), a gut-wrenching tale of a "stone butch", a "he-she", a woman who looked, dressed and acted like a man in Buffalo, NY in the '50s and '60s, the act that author Leslie Feinberg identified as healing for the protagonist was simply to speak.

Simply speaking is a problem for many women. The researchers referred to above, including Gilligan (1982), Brown & Gilligan (1992), Belenky, Clinchy, Goldberger, and Tarule (1986), and Jack (1991) have written in the last twenty years about women and voice. Each of these writers proposes in her own way that in failing to speak, to represent oneself and one's needs and opinions, women become vulnerable to many of the problems that face them. Among those problems are diminished status, low self-esteem, isolation, and mental illness, including depression. Jack (1991) has established a strong relationship between self-silencing and depression in women, as has

Koropsak-Berman (1997). Interestingly, Koropsak-Berman found that while the men in her sample self-silenced as much as women did, that self-silencing did not place them at risk for depression. These writers also all point to the fact that this is a problem for not just a few women; that in white, middle class, Euro-American culture, many, and perhaps most, women are silent at their own expense.

At the crossroads of silence are lesbians. They are female, having been taught to take up little space, to demand little, to misrepresent themselves when in conflict with a loved one, and to avoid confrontation (Chodorow, 1978; Brown & Gilligan, 1992). They are homosexual, needing to hide and be silent merely to survive. One wonders, then, about the cumulative impact of these two conditions in which silence is so embedded. Are lesbians the most silenced people of all? What role does "silencing the self" play in the lives of lesbians?

Statement of the Problem

The complete absence of systematic study and the paucity of relevant literature makes depression in lesbians an unexplored phenomenon. Theorists have done little to explain the gender difference in the prevalence of depression, to say nothing of the experience of depression among lesbians. Using feminist theory and critique, a more phenomenological perspective, and ethnographic research methods, researchers have developed ways of thinking about depression in women that take into consideration the context of the woman and the milieu in which she was reared (e.g., Chodorow, 1978; Chodorow, 1989; Belenky, et al.,1986; Jack, 1991). The information yielded from these studies is a valuable tool in beginning to explore depression in lesbians.

One of the recently developed ways of thinking about depression in women in general is in terms of self-silencing and its relationship to depression (Jack, 1991). Jack

(1991) demonstrated in this investigation that white, heterosexual women who silence themselves are at increased risk for depression. Jack's model holds that the degree to which a woman silences herself in her primary, intimate relationship will be closely related to depressive symptoms. Koropsak-Berman's (1997) work supports this; in her study of white, heterosexual women and men, she found that women who self-silence are at increased risk for depression while men who do the same are not. If lesbians silence themselves the same way that heterosexual women do, and if silencing has the same relationship to depression as it does with heterosexual women, lesbians would share the same and perhaps greater risk for depression as their heterosexual counterparts. However, it is also possible that lesbians' style is more like mens', in that self-silencing is present but does not create risk. Thus it is thought that sexual orientation may be a moderating variable in the experience of depression in women.

There are important theoretical reasons to predict differing degrees of depression in lesbians than in heterosexual women. Some social circumstances that place one at risk for depression are experienced disproportionately among lesbians when compared with heterosexual women, including isolation, ostracism, and lack of family support. Conversely, there are circumstances that place one at increased risk for depression that are experienced by some heterosexual women disproportionately, such as sole responsibility for child care, being in a relationship with a man, not having a paying job, and fear of ostracism by family if she leaves her marriage. In addition, lesbians have been found to have better general adjustment and less depression than heterosexual women (Rothblum, 1990; Griffith, Myers, Cusick, & Tankersley, 1997). Lesbians share with men some factors that are protective against depression, including working for pay outside the home, being in relationships with women, and decreased responsibility for child care, and men are at lower risk for depression than women. This might lead to the expectation that

for lesbians, self-silencing and depression are unrelated, as is the case with men. (Koropsak-Berman, 1997.)

There are also important theoretical reasons for predicting that lesbians are different from heterosexual women in their self-silencing behavior. Lesbians almost invariably buck messages of right and wrong and normality to live their sexuality. In addition, if a lesbian is out she has had a powerful unsilencing experience. In spite of this, lesbians are women, and can be assumed to have been taught the same lessons as other women have been about subverting one's own desires to fulfill the desires of others. In addition, many lesbians must live day-to-day with a lot of invisibility, and often must keep silence for safety.

The literature does not give a clear picture of the experience of depression in lesbians. New feminist models of depression have not been applied to this population. It would be valuable to explore the fit of Jack's silence model of depression with a lesbian population and a heterosexual reference group to begin to understand the nature of the experience of depression in lesbians. In addition, it would be useful to explore the role of the coming out process in self-silencing and depression, as coming out is a kind of unsilencing process. Perhaps it is the case that needing to be free from silencing in one area of life facilitates unsilencing in other areas.

Purpose of the Study

The purpose of the study was twofold. First, the investigator sought to describe the sample under study, in order to better understand the everyday lives of lesbian women. The second purpose was to explore the relationship of self-silencing and depression in lesbians and heterosexual women, by extending the research of Jack (1991) and Koropsak-Berman (1997). While it might be assumed that relationship is the same or

similar to the relationship observed in women in general, there are important factors that indicate that differences might exist. Those factors include different primary romantic relationships, differences in employment and parenting patterns, the effects of coming out, effects of social opprobrium, and others (Rothblum, 1990).

To achieve the purpose of this study, two variables were observed. Specifically, the prevalence of self-silencing (as measured by the Silencing the Self Scale) among lesbians and heterosexual women was compared, as was the prevalence of depression (as measured by the Beck Depression Inventory) among these two groups. Self-silencing and depression was correlated in each group, to determine whether self-silencing predicted depression in each of the groups. Finally, the investigator examined differences in the ability to predict depression from self-silencing between groups.

In addition, it is potentially valuable for psychologist and other mental health professionals to have information about how depression in lesbians can be both similar and different from depression in other women. This could aid in developing treatment plans and in having theoretical bases upon which to choose interventions. Finally, it remains unknown whether there is a causal relationship between the self-silencing and depression. While this study does not seek to establish such a relationship, it can contribute to a better understanding of the phenomenon, perhaps contributing to clarification of the issue.

Research Questions

1. A) What are the demographic characteristics of the subjects by total group and by sexual orientation (lesbian and heterosexual women)?

   B) How representative is the sample compared to census data?

2. What degree of self-silencing as measured by the Silencing the Self Scale (SSS) is reported for the total sample and for lesbians and heterosexual women and do the groups differ on this measure?
3. What degree of depression as measured by the Beck Depression Inventory (BDI) is reported for the total sample, and for lesbians and heterosexual women and do the groups differ on this measure?
4. What factors emerge from an analysis of the SSS and how do they compare with Jack's seminal work?
5. What is the relationship between the demographic variables of the subjects and scores on the SSS and the BDI?
6. Do differences exist between groups in any of the relationships between the demographic factors and depression and/or self-silencing?
7. Are there differences between groups or on any demographic variables in the degree to which self-silencing predicts depression?
8. Is stage of coming out as measured by the Stage Allocation Measure related to self-silencing and/or depression in lesbians?

Contributions of the Study

Depression puts people at risk in many ways, including isolation, difficulties in functioning, health problems, and suicide (APA, 1994). Despite the clear need, little research has been undertaken to illuminate the experience of depression in lesbians. This study provided information about this experience. Specifically, information was gleaned about the prevalence of self-silencing and depression in the sample studied, including the relative prevalence of these phenomena in lesbians and heterosexual women. Lesbians' responses to the Silencing the Self Scale provided data about their ways of being in

relationships. In addition, Jack's Silencing the Self model of depression in women was evaluated in terms of its appropriateness for lesbians.

Aside from the information provided about lesbians, self-silencing, and depression, the study provided information about the connection between gender and depression. While Jack's study correlated depression and self-silencing, it remains unknown whether it is silence in the primary romantic relationship, as Jack proposes, that predicts depression. Exploring patterns of lesbians' silence in their primary relationships and in their worlds (i.e., how "out" they are) may shed some light on this topic.

Definition of terms

Coming out refers to the process of acknowledging to oneself and others that one is lesbian, gay, or bisexual. (Martin, 1991).

Homosexuality is defined by Kinsey (1948) as "sexual relations, either overt or psychic, between individuals of the same sex."

Lesbian is considered by Kinsey (1948) to be the word for the female equivalent of "homosexual."

Silencing the self is to fail to articulate one's desires or to behave inconsistently with one's desires because of the perception that one must do that to remain in connection with another and the eventual loss of connection with self that results from the failure to represent one's experience (Jack, 1991).

Chapter 2

Review of the Literature

Introduction

There has been little direct inquiry into the experience of lesbians and depression. Accordingly, several other areas of literature that converge on this topic will be examined. Those areas include a brief discussion of depression, as well as a discussion of theory of depression and its differential prevalence in women. This will be followed by a review of literature about social forces that impact women's lives and relationships. Qualitative research regarding women, women's development, self-silencing, and depression will be examined. Finally, the small amount of literature that exists about lesbians and depression will be described, and predictions will be made based on the theory presented in the chapter.

Depression

Depression is one of the most common psychiatric disorders. Roughly one in eight adults will experience depression in his or her lifetime. While the typical age of onset seems to be dropping, the average age of onset is around the mid-twenties. Those with parents, siblings, and children with depression have a 1.5 to 3 times higher risk of depression than those with no such family history. Moreover, with each episode of depression, the likelihood for another episode increases. (American Psychiatric Association, 1994.)

Depression has serious implications. Up to 15% of individuals with depression attempt suicide, and elderly persons diagnosed with depression have significantly higher morbidity and mortality than do their non-depressed counterparts. In addition, depressed

people by definition experience significant impairment in functioning in one or more of social, occupational, and community roles. (APA, 1994.)

Depression is a complex illness. It involves biochemical, psychosocial, and hereditary factors, and significant breakthroughs have been reported in these domains in recent years (Weissman & Klerman, 1987.) Beck, Rush, Shaw, and Emery observed in 1979 that "the prevalence of depression is not decreasing, nor is the suicide rate attenuating" (p. 1). In 1992, Klerman and Weissman, in an extensive review of the literature on the epidemiology of depression, found that more people have suffered from depression in each cohort since World War II, and that the age of onset is earlier for each cohort as well.

Gender and Depression

One of the complexities that faces us when we look at depression is the difference in prevalence rates between men and women. Women are two to three times more likely to be diagnosed with depression than men (National Institutes of Health, 1997). Until recently, there has been little interest among personality and developmental theorists in the etiology of this gender difference in prevalence of depression. This assertion is borne out by the lack of research on the subject or discussion of the gender difference by personality theorists.

Nevertheless, theoreticians have had plenty to say about depression in general. Freud in "Mourning and Melancholia" (1917) insightfully described the similarities between mourning and depression (he called it "melancholia"), arguing that depression is mourning gone awry. He recognized that symptoms for depression and mourning were identical except that in depression there is excessive self-criticism. Freud believed that this verbal aggression was masked aggression against the object experienced as lost, though the object may continue to be present in the depressed person's life. In Freud's

work we see the emergence of understanding of the themes of relatedness, attachment, and loss that have become the core around which inquiry into women's depression now revolves in some circles. Conversely, we also begin to see a finger pointed at the sufferer of depression – rather than being thought of as a person experiencing mourning, that person is construed as pathological. Ironically, the self-recrimination that is the identifying symptom of melancholia is the symptom that is labeled pathological, giving the sufferer that much more ammunition against herself. Later theorists added to this view of depression the notion that orality and dependency are precursors to depression in adulthood (St. Clair, 1986).

More recent psychodynamic thinking takes a slightly different approach. Ego psychologist Bibring (1953) described depression as a desire to attain certain goals, and seeing oneself as being unable to achieve them. Bibring argued against the traditional psychoanalytic notion that oral fixations create a predisposition to depression, but he did say that most commonly depression occurs in orally dependent people. Object relations theorist Edith Jacobson described depression as the loss of a loved object as did early Freudians. She added that the depressed person, who in childhood had harsh and punitive parents, learns that love and rage are intertwined. The child cannot identify in a positive way with the parent, and when she experiences loss she feels rage and devalues both the other, for disappointing her, and the self, because the self has identified with this other. If the other is to be devalued and the self is closely identified with the other, it closely follows that the self will be devalued as well. (St. Clair, 1986; Harris, 1987) Jack asserts,

> Though John Bowlby and other theorists detail the interpersonal nature of depression, their writings reflect a startling omission. They do not examine the effects of gender, either on the experience of the self or on the experience of relatedness. While stressing the social nature of the mind and experience, they overlook the fundamental patterning of gender on consciousness and behavior. (Jack, 1991, p. 14.)

Cognitive theory avoids the loaded verbiage that can weigh down psychodynamic theory. However, it provides little help in understanding the disproportionate incidence of depression in women. Beck, in his cognitive model of depression, posited that three constructs explain depression. The first construct, the patient's cognitive triad, specifically her view of herself, her future, and her experiences, is overwhelmingly negative. Secondly, the schemata, or stable cognitive patterns, enacted when the individual is processing stimuli are those that involve negative evaluations and expectations. Third, depressed individuals make cognitive errors, or systematic errors in thinking that work to sustain her negative beliefs (Beck et al., 1979). This model offers no inkling of how women might come to be at greater risk for depression than men. It could be argued that a cogent, solid theory of depression does not need to explain the gender split to facilitate effective therapy. However, it must explain the split to aid in prevention.

Cognitive and psychodynamic theories of depression are widely used by practitioners to understand depression in their clients. Both of these theories have some important shortcomings in explaining the nature of depression, particularly inasmuch as they fail to address the issue of the disproportionate number of women suffering from the disorder. Other commonly used theories, including behaviorist and humanist theories, also offer a paucity of theoretical understanding of the differential prevalence of depression between the genders. It seems theorists were willing to assume that there is simply more psychopathology among women – it does not even seem to have occurred to them to ask the question. Gilligan summed it up as follows:

> The disparity between women's experience and the representation of human development, noted throughout psychological literature, has generally been seen to signify a problem in women's development (1982, pp 1-2).

Women and the Social Milieu

Since Simone de Beauvoir's The Second Sex (1949) there has been considerable academic discussion about the social forces at work in the lives of women. Betty Friedan (1963) wrote about the "feminine mystique" – Friedan's term for the patriarchal set of rules of conduct that are brought to bear when women's lives were evaluated. In both of these works, women were portrayed as a group that had been, in effect, divided and conquered. Both authors described the remarkable resignation with which women marry, have children, care for a household, take on incredibly difficult lives even in the best circumstances, and even describe for an interviewer the loss of themselves. It seems that these writers were writing about depression without ever naming the entity.

Friedan (1963) observed that there was a system in place, remarkably difficult for women to avoid, in which they were placed on a track with only one destination. They could marry and have children, and that was about it. Those who tried to resist usually failed, and were held up as lessons to other women with grand notions. She described the anger of college seniors whom she spoke with in a small group. Those that were engaged to be married were angry with those who weren't because they believed the non-engaged women thought less of them for marrying readily. They were quick to argue that the other women would end up following suit quickly. The women who were not engaged were angry because they had no idea what to do with themselves. For them, it seems, academia showed them worlds that they wanted to explore, but the women were faced with the reality that to really pursue those dreams would prove prohibitively difficult, because of the lure, or perhaps the brute force, of the "feminine mystique."

In discussing depression in the people they interviewed, Jack (1991) and Gilligan (1982) relied heavily on de Beauvoir's, Friedan's, and other feminist writers' notions about feminism, femininity, and oppression, while conducting the discussion in

psychological terms. Both Jack and Gilligan observed the same kinds of things that the earlier writers observed, such as deep helplessness and resignation, wishes that things could have been different, and sense of overriding what one knows and wants in order to fit in. These authors, however, saw through the lens of their psychological training, and they labeled what they were seeing depression. Gilligan (1982) forged an important link between social force of the patriarchy and the depression experienced by individual women.

Attachment theory is another critical link between the way women are socialized and women's depression. John Bowlby's work contributed a wealth of important ideas to psychology about the way mothers interact with their children, and children with their mothers, as well as the consequences of the interactive patterns, or attachment styles. He gave us a model for understanding attachment and the adaptiveness of that attachment. This model provides three descriptive classifications of attachment. Interestingly, the best adapted child is not, according to Bowlby, the individuated, independent child. Rather, the child who is both connected to her mother and interested in the world is seen as the child with the most healthy, or secure, attachment. A securely attached infant is one who explores the world with interest and engagement, while referring back to mother for assurance. Securely attached infants also seek contact with mother when distressed by a brief separation. An infant that is insecurely attached, or anxiously attached, either avoids mother after a separation, or oscillates between clinging to her and avoiding her. These two kinds of attachment are anxious-avoidant and anxious-resistant. Bowlby went on to say:

> That attachment behaviour in adult life is a straightforward continuation of attachment behaviour in childhood is shown by the circumstances that lead an adult's attachment behaviour to become more readily elicited. In sickness and calamity, adults often become demanding of others; . . . In such circumstances an increase of attachment behaviour is recognised by

> all as natural. It is therefore extremely misleading for the epithet "regressive" to be applied to . . . attachment behaviour in adult life, as is so often done in psychoanalytic writing where the term carries the connotation pathological or, at least, undesirable. . . To dub attachment behaviour in adult life regressive is indeed to overlook the vital role that it plays in the life of man from the cradle to the grave (pp. 207-208).

Bowlby provided valuable tools so that psychologists no longer must think that strong attachment in adulthood is pathological. For someone to determine how these tools could change how we conceive of women and their experience of depression still remained. Several writers have contributed to a more empathic, socially focused understanding of depression in women. In Feminism and Psychoanalytic Theory (1989), Nancy Chodorow argued that it is the intrapsychic experience of boys that leads to the marginalization and pathologizing of women's need for attachment. Her thinking at that time was that boys are primarily raised by their mothers, and much of what they know about people comes from their interactions with their mothers. However, they discover that women are devalued by society, and that men are valued. As a result they strive to be what their mothers are not. In adulthood, they unconsciously turn this around, and define the feminine as that which is not-masculine. Since individuation is what men perceive they had to do, it is held up as the norm, and the need for attachment is pathologized.

Ethnography and Women's Voices

In her 1982 book, In a Different Voice, Carol Gilligan described her heightening awareness in the 1970s that women were choosing to speak. In response, she says, she decided to listen. She listened to women's stories, and specifically listened for voice; that is to say, who the woman was really speaking for or about when she was talking. She asked the women she interviewed about themselves, about moral choices, and about their

relationships. From this, Gilligan devised her technique of exploring narrative, which would be further refined in her later work.

In 1986, Belenky, et al., used a method much like Gilligan's in their Women's Ways of Knowing. They interviewed 135 women, and told them they were interested in hearing about their experiences. The interviews were from 2 to 5 hours in length. Subsequently, the researchers listened to each interview for five different epistemological positions, including silence, received knowledge, subjective knowledge, procedural knowledge, and constructed knowledge. Each of these positions represents a progression from voicelessness to "creators of knowledge." Using this frame for analyzing the narratives, the authors described each of the types of knowledge using the women's own words to illustrate points.

In their Meeting at the Crossroads, Brown and Gilligan (1992) attempted to document girls' experience in their own words, much as Belenky et al. did in Women's Ways of Knowing. They undertook a qualitative study of girls, ages 7 to 18, to investigate what they called "the crisis in women's development." They found that:

> . . . an inner sense of connection with others is a central organizing feature in women's development and that psychological crises in women's lives stem from disconnections (p 3).

After false starts and much revision, the researchers developed a list of possible questions, but determined that the larger issue in the interviews with girls was to stay with their stories and provide space for description and expression of their interpersonal conflicts. They then listened to each interview four times. For each listening there was a corresponding question, directed toward hearing the voice of the girl being interviewed. The first listening was to determine who was speaking; the second, in what body; the

third, telling what story about relationship – from whose perspective or from what vantage point; and the fourth, from what societal and cultural perspective.

Brown and Gilligan asserted that their data indicate that girls in the range included in their study experience a "going underground," and they carefully traced this phenomenon. At age 7 and 8, they described the girls as follows:

> These seven- and eight-year-old girls say matter-of-factly that people are different, that they may disagree, and as a result, sometimes people get hurt. While they speak about the importance of being nice, they openly acknowledge that sometimes they do not feel like being nice; they know that they can hurt others, and they speak about being hurt by others. In this sense their relationships seem genuine or authentic (p 43).

Ten- to thirteen-year-old girls begin to experience a lot of conflict. The researchers still heard, albeit often veiled beneath layers of self-censorship, a true voice, a sense of fair and unfair, an awareness of need and health. But the girls begin to experience conflict in relationship as threatening. The girls begin to believe that others with whom they want to maintain a relationship have opinions and ideas that are more correct than their own. They begin to suppress their sense of unfairness and awareness of their own needs. Often the girl begins to describe an incident as unfair or as an example of poor treatment, and ends the discussion with a concession that the right thing happened, and that her initial indignation was wrong.

Brown and Gilligan discussed twelve- to fifteen-year-old girls as a sort of early outcome – the tremendous difficulties and rewards for resisting, the price of concession, and the disaster of true disconnection from one's experience. The researchers traced the profound silence of one of the girls discussed in the section on early adolescents, to eventual disorientation to self, and ultimately to a downward spiral into an abusive relationship with a boyfriend and an eating disorder.

Using the narrative method, Brown and Gilligan have delineated a model for thinking about the psychosocial development of women. First, they say, girls are astute observers of the interpersonal world. They gather information, and act in ways that are based on essentially healthy underpinnings. They understand that conflict is part of life, and don't devalue individuals based on a few behaviors. Approaching adolescence, girls become much more concerned about loss of connection. At this time, conflict is seen as much more dangerous, and so girls are much more circumspect about sharing a point of view that they perceive as likely to generate conflict. However, the danger is twofold – the girls may lose relationship to others if they cause conflict, but they stand in jeopardy of losing their relationship with themselves if they fail to say what they see. Ultimately girls make the decision. While it is hard to remain confident enough to believe that connection with oneself is more worthwhile than capitulation to others, it is ultimately the road to healthy relationships. The consequences of the decision to value attachment with others over connection to the self are grave – at the very least, one has lost a valuable part of oneself. Other consequences of this disconnection, they claim, include depression, eating disorders, and anxiety.

Silencing the Self

Dana Jack, self-described as a traditionally trained therapist, writes:

> I was constantly dissatisfied with my comprehension of recurring themes such as loss of self, self-condemnation, and hopelessness. My difficulty in understanding depressed women's experience did not reside in the hollows or silences of their narratives; the difficulty arose because what they said was so familiar and I had already been taught how to interpret it. . . As I began to hear more clearly with the help of recent developments in the psychology of women, it appeared that major concepts used in theories of depression – attachment, loss, dependence, self-esteem – required reexamination from a depressed woman's perspective (Jack, 1991, pp 2-3).

In writing about women and depression, Jack trained the focus on the interpersonal. She argued that our society holds up individuation and self-sufficiency as the gold standard of maturity. By this measure, women, who are more interpersonal creatures, will always come up short. However, if women are thought of in their own context – one of interrelatedness and interdependence – a very different standard is needed to cast a model of normal development. Against the background of interdependence, the phenomenon of depression in women stands out in bold relief. When the need for intimate connection is not met, women experience loss. Because they have been taught the model of normality, or male normality, that independence is maturity, women criticize themselves for needing this attachment – they should be independent like their fathers, husbands, and brothers. And as Freud, among others, has told us, self-recrimination added to loss is the formula for depression.

Jack's work on depression in women is closely in step with Brown's and Gilligan's work. Jack asserted that sacrificing genuineness and honesty in relationships for fear of losing connection itself is the road to a different kind of loss. While the loved one remains in the woman's life, she has given up real connection for the illusion of it. Women do this because they are taught to focus on the needs of others in relationships, and that if the relationship fails, it is indicative of the failure of the woman to be selfless. However, this selflessness comes at a great cost – the woman eventually loses the relationship she seeks to tend, or she is left with an unsatisfying shell of what she really wants.

Jack argued that depression in women is not entirely, or even mostly, an issue of psychopathology. She also argued that human beings in general, and women in particular, are relational; we are socialized to be so. The homeostatic state for women is in relationships in which one can remain attached while tending to one's own needs, values,

perceptions, and ideas. The absence of this type of relationship in a woman's life leads to the sense of loss and self-criticism that in turn leads to depression.

When Jack discussed the ways in which women learn to silence themselves in the service of connection, she closely examined the mother daughter relationship. She posited that the mother teaches the daughter to evaluate herself by imposing the values of the external world, what Jack calls the "generalized other," upon the daughter's internal world. Hence, the woman brings such values as materialism and independence to bear in judgement of herself when in fact she does not herself value these constructs. Further complicating this transfer of knowledge is that the daughter is often responsible for the emotional needs of her bereft, isolated mother, and so learns that caretaking is her lot in life; she is to be evaluated by how good she is at taking care of others. The young girl comes to believe that she is responsible for others' behavior that she is in no way able to control. Finally, young girls become confused when they are taught at home that giving and caretaking are the goals of being female, and then they experience society, friends, and partners who tell them they are weak for not asserting themselves. Jack concluded:

> This must be the ultimate silencing: to take the culture's perspective, or the partner's perspective, on the self and condemn a human need for intimacy and mutuality . . . [when] her depression demands that she listen to what she knows from her unique experience of living, from her own feelings, and from her body. (Jack, 1991, p. 158).

It is this self-silencing that ultimately leads to the loss of self which in turn may lead to the devastating loneliness and depression experienced by women without real connections.

Qualitative Meets Quantitative: The Silencing the Self Scale

Having identified through her longitudinal, ethnographic study the notion that depression in women is intimately tied to relatedness, Jack set out to develop a scale that would measure the degree to which women had silenced themselves and establish a relationship between that silence and depression (Jack, 1991; Jack & Dill,1992). She included subscales. It should be noted that these were rationally and not experimentally derived.

1. externalized self-perception (judging self by external standards);
2. care as self-sacrifice (securing attachments by putting the needs of others before the self);
3. silencing the self (inhibiting one's self expression and action to avoid conflict and the possible loss of relationship); and,
4. the divided self (the experience of presenting an outer compliant self to live up to feminine role imperatives while the inner self grows angry and hostile).

Jack predicted that women who share a social/relational status would demonstrate high correlation between depression scores and the Silencing the Self Scale (SSS). Groups of women who have different social/relational status would differ significantly in their degree of endorsement of SSS.

The scale was given to 63 undergraduates (mostly European-American, single, without children), 140 women from three battered women's shelters, and 270 European-American women participating in a study examining cocaine use in pregnancy (all self-reported drug use during pregnancy.) The samples were construed to be a non-depressed group, a mildly depressed group, and a very depressed group, respectively. The SSS and the Beck Depression Inventory (BDI) were given to all participants. Test-retest reliability in all three samples was strong. SSS and the BDI correlated significantly in all three

groups. SSS and BDI varied significantly between groups as well. From this, Jack concluded that self-silencing is a predictable phenomenon if certain facts are known, and that it is reliably associated with depression.

Koropsak-Berman (1997) conducted an investigation in which she gave the SSS to undergraduate females (n=100), undergraduate males (n=76), and women in battered women's shelters (n=70). She found the same pattern as Jack did, which is to say that undergraduate women were significantly less depressed and less self-silenced than were the women in the shelter. In addition, she found that undergraduate men were significantly less depressed than undergraduate women; however, they only differed from undergraduate women on the SSS on one subscale, externalized self-perception. Koropsak-Berman repeats Jack's conclusion that self-silencing puts women at risk for depression. However, Koropsak-Berman adds an important finding to Jack's; that self-silencing does not seem to put men at risk for depression.

Lesbians and Depression

In their classic work, Sexual Behavior in the Human Male, Kinsey, Pomery, and Martin (1948) define homosexuality as follows:

> . . . the term homosexual . . . has been applied to sexual relations, either overt or psychic, between individuals of the same sex. . . The term Lesbian, referring to such female homosexual relations as were immortalized in the poetry of Sappho of the Greek Isle of Lesbos, has gained considerable usage with recent years, . . . Although there can be no objection to designating relations between females by a special term, it should be recognized that such activities are quite the equivalent of sexual relations between men. (pp. 612-613)

Kinsey et al.continue:

> Long-time relationships between two males are notably few. Long-time relationships in the heterosexual world would probably be less frequent than they are, if there were no social custom or legal restraints to enforce continued relationships in marriage. But without such pressures to preserve homosexual relations, and with personal and social conflicts

> continually disturbing them, relationships between two males rarely survive the first disagreements. (p. 633)

It is obvious that when Kinsey, et al., talk about homosexuality, they are clearly discussing genital sexual activity. Kinsey, et al., seem certain that homosexual men cannot have meaningful, long-term relationships, and they clearly state that they do not believe lesbianism to be in any important way different from male homosexuality. We may justifiably conclude, therefore, that Kinsey, et al., do not believe that long-term relationships are part of lesbianism either, although they never directly state this in either Sexual Behavior in the Human Male (1948) or Sexual Behavior in the Human Female (Kinsey, Pomeroy, Martin, & Gebhard, 1953).

Whether things have changed since Kinsey's, et al., time, or whether they missed important facets of homosexuality, it is nevertheless clear that this construction of homosexuality is no longer an appropriate way to continue any discussion on homosexuality (Rankow, 1996; Eliason, 1996). Homosexuality is now spoken about as an identity issue rather than one of sexual behavior (i.e., Cox & Gallois, 1996; Eliason, 1996; Morris, 1997; Meyer & Schwitzer, 1999; Rosenfeld, 1999 Eliason, 1996). It can define where one lives, with whom one associates, where one works and even in what field one works, as well as many other aspects of life (i.e., Boatwright, Gilbert, Forrest, & Ketzenberger, 1996; Dunkle, 1996; Gamson, 1996; Morris, 1997; Smith & Windes, 1999). Genital sexual activity, in these cases, becomes rather a secondary issue, or at the very least, one part of a much larger whole.

Stein (1999) has identified various ways in which homosexuality can be measured. He delineates three ways of identifying who is homosexual and who is not. First, this can be done by asking for or observing a sample of behavior. This is the Kinsey model revisited with all of its attendant problems. Second, sexual orientation can be

determined by what Stein calls the "dispositional view", which takes into account the person's disposition to engage in behavior, as well as her desire to do so. This allows for how the person perceives herself, but it also considers what she actually does. However, he notes that in order to assess the disposition and the desire of the individual to engage in behavior, one must have counterfactual information. That is, we must know what the individual *would* do in situations that do not exist. For example, it would be useful to know whether, if there were no cultural injunction against homosexuality, the person would engage in homosexual behavior. Knowing this kind of information is almost impossible in this type of inquiry. Thirdly, Stein notes that we can use a self-identification model, in which the individual simply says what she calls herself.

> The self-identification view says that if someone really believes he or she is a heterosexual, then he or she is. . . This view has the problem of not allowing for self-deception. It is possible for (someone) to be a homosexual without him believing, even in his heart of hearts, that he is a homosexual. . . People are fairly reliable in reporting their sexual orientations, but in some cases, this can be trumped. (Stein, 1999, p. 45)

Asking participants to simply identify themselves does make the investigation vulnerable to manipulation by participants. However, it is the most realistic and the most respectful way to capture the data.

There is a striking paucity of literature about lesbians and depression. Rothblum (1990) reviewed existing literature on lesbians and depression. She noted that there has been almost no systematic study of lesbians and depression. This gap in the literature remains eight years after Rothblum's review. To examine the phenomenon of lesbians and depression, Rothblum undertook a two-pronged approach to reviewing the literature. She examined social factors known to put people at risk for depression, and evaluated the relative presence of these factors in lesbians' lives. In addition, she reviewed what work

had been done on lesbians' mental health and made connections between other mental health problems and risk for depression.

Rothblum looked at sexual orientation as a moderating variable in the experience of depression in women. Social risk factors for depression examined by Rothblum included lack of social support, partner relationships, mothering young children, and lack of paid employment. To some degree, lesbians are protected from these factors. Lesbians who are in committed relationships are protected from depression in a way that their heterosexual counterparts are not. Leavy and Adams (1986) found improved self-esteem in lesbians in relationships, while there is a substantial body of literature indicating that married heterosexual women are at increased risk for depression (Rothblum, 1983). Lesbians are less likely than heterosexual women to be mothers of young children, and if they are, they tend to share caretaking duties with their partners. Lesbians overwhelmingly are paid workers (75 – 80%) and are protected in this way as well.

However, Rothblum pointed out that other social factors impinge on lesbians in ways that they do not with heterosexual women. For one, lesbians have much less support from family than other women. In addition, social opprobrium for lesbian relationships and child rearing, and concern about being out in the workplace may serve to undermine the protection given by lesbians' relationships, motherhood status, and work force participation. Unique risk factors that may put lesbians at increased risk for depression include alienation from heterosexual society, coming out, and difficulty integrating into a lesbian community.

Rothblum examined the little literature that exists about lesbians and mental health problems and their relationship to depression. Lesbians' reports indicate that they are two and a half times more likely to attempt suicide than heterosexual women, and these rates are higher among non-White lesbians. Rothblum reported that alcohol abuse

is widespread among lesbians. She warns that this may or may not be a good indicator of depression; for lesbians a major social outlet is the bar scene, and this may be part of what is reflected in drinking patterns. Sexual abuse suffered by lesbians is around 37%, according to the National Lesbian Health Care Survey (National Institute of Mental Health, 1987). Among Latina and African-American lesbians, this figure goes up to about 50%. While there are no controlled studies examining rates of sexual abuse among lesbians and comparing this to heterosexual women, these numbers seem to be in line with statistics reported for the general population of women, or perhaps slightly higher. It is well to remember also that some physical and sexual assault is a direct result of being perceived to be a lesbian. The last mental health issue examined, general psychological adjustment, seems to be stronger in lesbians than in heterosexual women.

An incidental finding in a 1997 study by Griffith, Myers, Cusick, and Tankersley provided an unusual piece of direct evidence about lesbians and depression that is small but important. They examined MMPI results of four groups consisting of women with and without abuse histories and women who identify as homosexual and heterosexual. A general finding was that homosexual women had lower scores on the depression scale than heterosexual women. Given the conclusions of these investigations, there is reason to think that lesbians are no more depressed, and perhaps less depressed, than heterosexual women.

Applying Jack's model to lesbians

In Silencing the Self, Jack spoke exclusively of heterosexual relationships. Implicit in her notions of silencing the self is that the social construction of both genders – what it means to be male and what it means to be female in this culture – dictate the behavior and identity of women in romantic relationships. That is to say, women

understand their role to be that of pleasing the man and taking care of his needs, and that her needs are secondary because of her gender *and* of his gender. The man's gender entitles him to her submission, and the woman's femaleness is her mandate to be submissive.

If the construction of both genders impacts on the woman's behavior in an intimate relationship, then important parts of the social script are missing from a lesbian relationship. Specifically, if a woman is taught to accomodate men, and there is no man in the relationship, that schema would not be activated. In addition, there is no man to believe in his entitlement to the woman's submission, and another cue to activate a woman's submissive, other-focused behavior is missing. Therefore, we would expect to see less self-silencing among lesbians in the absence of these social cues.

Jack did, however, allow for the possibility that it is not simply in the male-female romantic dyad that this self-silencing is enacted. Jack discussed this in her treatment of mothers and daughters (see above.) In addition, she made an important point that qualifies her emphasis on romantic relationships, and by extension mitigates the effects of maleness, as the crux of the self-silencing problem. She noted that failing to silence the self in heterosexual relationships harbors the threat that a woman is not only going to lose her intimate relationship, but also her family's positive regard. This leaves the possibility that there is something more at work in the self-silencing that women engage in than simply schemata enacted by the presence of a man in her life; there is as well fear that stems from the threat of alienation from family members other than the romantic partner.

Making predictions: A Summary

There are theoretical and empirical reasons to support a position that lesbians will silence themselves more than heterosexual women. For example, the tendency for

lesbians to fuse in relationships (Mencher, 1990), to lose their sense of individuality, and their ability to identify their own, individual experiences seemingly puts lesbians in serious jeopardy of self-silencing, and the depression that self-silencing might lead to. The finding that lesbians are twice as likely to attempt suicide as their heterosexual counterparts also supports this prediction. Lesbians themselves are not immune to homophobia and this can be an added source of stress and lack of self-esteem (Sophie, 1987). Added to the potential for profound disconnection from family and social ostracism experienced by lesbians, a strong case is made for the expectation that higher rates of self-silencing would be found among lesbians, and by extension, higher rates of depression.

Upon closer examination, however, there are clear reasons for predicting lesbians would be less self-silenced and therefore less depressed. Importantly, Jack focused on the intimate dyad as the main arena for self-silencing. If this is an accurate model, then we must predict one of three things. The first possibility is that lesbians are less silenced in their primary relationships. This hypothesis is supported by evidence that lesbians are less depressed when in relationships, as well as some evidence that lesbians score higher on measures of general psychological adjustment, and lower on depression scales than do their heterosexual counterparts.

Another possible hypothesis is that there is no relationship between self-silencing and depression in lesbians. That is, it could be that lesbians do silence themselves, but this self-silencing does not lead to depression in the same way that Jack hypothesizes it does in heterosexual women. This is argued against by the fact that lesbians generally have a tremendous "unsilencing" experience by coming out to self, family, and friends – one that is motivated by a need for psychological and social congruence (Browning, 1987). This implies that the silence of not coming out generates intense discomfort. It

may be that the degree to which a lesbian is unsilenced is related to her stage of coming out, as measured by a scale such as Cass's (1984).

There are additional factors that make a lack of relationship between these two variables unlikely. For one thing, lesbians are raised to be women. They are trained to tend relationships and need connection just as other women are. This need for connection can be seen in the tendency of lesbians to "fuse" with their partners. Finally, the "fusion" seen in lesbian relationships can alternatively be seen as an antidote to self-silencing. Having the experience that another person fully understands the self and can articulate the experience of the self is one that lesbians clearly seek, evidenced by increased rates of depression in lesbians who are single, and by the narratives of lesbians in strong, long-term relationships.

Finally, one could hypothesize that Jack's model is inapplicable to lesbians; because of the number of outside stressors that impinge on lesbians' day-to-day lives, the primary intimate relationship is not as central as it is for heterosexual women. However, this hypothesis can be tested simultaneously with the hypothesis that lesbians are less silenced in their primary relationships; if it is found that lesbians are equally or more depressed than a heterosexual reference group, but are less silenced, it can be concluded that factors external to the primary romantic relationship are at work in lesbians' experience of depression.

It seems, then, that theory would weigh in heavily on the side of lesbians being as silenced and depressed or more than their heterosexual counterparts, with a few exceptions. However, many of the works reviewed support the opposite conclusion: Rothblum's (1990) observation that lesbians are generally better adjusted than their heterosexual counterparts and that many of the factors that put heterosexual women at risk are either not present or mitigated in lesbians' lives; the Griffith et. al. (1997) finding

that lesbians have lower depression scores on the MMPI than heterosexual women; Jack's (1991) assertion that the quality of intimate relationships is an important key to protecting women from self-silencing and depression, combined with Rothblum's (1990) finding that lesbians in relationships are less depressed than those not in relationships. All of these lead to the prediction that lesbians will be less self-silenced than their heterosexual counterparts. Since they do not share the risk factor of self-silencing, lesbians will therefore be less depressed than heterosexual women.

Chapter 3

Methods

Introduction

In this study, the investigator attempted to answer the research questions posed in the first chapter and developed in the second chapter using methodology similar to that used by Jack (1991). However, because some questions and variables are unique to this study, the methods were tailored to best address the specific variables under examination here. All data were collected by the investigator.

Samples

Women were recruited to participate in this study through a variety of efforts. Political groups, social connections, and church groups were used. Recruitment efforts took place in three northeastern cities, including Providence, RI, Boston, MA, and Pittsburgh, PA. All participants were approached in person. Participation was rolling until enough subjects were obtained for analysis. A total of 170 women participated in this study. Of the participants, 85 were lesbians, 71 were heterosexual, and 14 were bisexual. The data collected from bisexual women was used only for demographics, and these women were excluded from all further analyses. In addtion, 11 women (two heterosexual and nine lesbian) failed to complete the reverse side of the BDI and were therefore excluded from all analyses involving the BDI. Efforts were made to recruit heterosexual women that have characteristics that are assumed to be like those possessed by lesbians in order to keep the two groups as similar as possible except for the dimension of sexual orientation. To that end, the investigator attempted to obtain a sample that was predominantly well-educated, employed for pay, and politically liberal. To do this, the

investigator recruited women from groups that can be assumed to have many members with these characteristics, such as members of local churches or activity-oriented groups (such as the Wilderness Women in Pittsburgh). In addition, attempts were made to recruit non-white participants. Data from fourteen respondents who identified themselves as bisexual were excluded from analysis. In addition, women identifying themselves as being in stages 1, 2, or 3, of development on the Stage Allocation Measure (described below) or who failed to complete the measure, were excluded from analysis, as these women are not lesbian nor are they heterosexual by their own description. (Two women were in Stages 1-3; two women who identified as lesbian did not complete the measure.) These attempts to recruit like samples that were diverse was met with only limited success.

Lesbians were recruited through several channels. Lesbian groups were approached, such as outdoor groups, reading groups, and political groups. Religious groups were approached, including diverse congregations of the Episcopal Church, Unitarian Universalist congregations, and Metropolitan Community Church congregations.

Leaders of groups were approached, and asked for permission and a time to approach their groups to participate, and a time was be scheduled. (See Appendix A for the script used to approach potential subjects.) Participants were provided time and space to complete the measures. The packet included an explanation of the study and informed consent (see Appendix B), a demographic form (see Appendix C), the Silencing the Self Scale (see Appendix D), the Beck Depression Inventory (see Appendix E), and Cass's Stage Allocation Measure (Cass, 1979; Cass, 1984) (see Appendix F). All measures were presented to all participants in the same order. All packets were collected on the occasion that they were distributed. The investigator was present on every occasion.

Research Measures

The Silencing the Self Scale and the Beck Depression Inventory were given to all subjects because they were the measures used in the seminal work by Jack. In addition, the lesbian participants were asked to rate themselves on Cass' Stage Allocation Measure. A demographic measure was used to collect additional information about the variables under test for all subjects.

Demographic Data Sheet and Identification of Sexual Orientation

The demographic data sheet provided information on variables that might influence either SSS scores or BDI scores. In addition, it provided information on the characteristics of the sample and potential limitations to generalizability based on sampling error. Data collected included age, relationship status, children, psychiatric history and medications, perceived social, family, community, and partner support, religious affiliation and background, occupation, socio-economic status, relationship history, and sexual orientation (see appendix C).

While most of the questions on the questionnaire were readily quantifiable, there was, perhaps, a problem in quantifying who is a lesbian and who is heterosexual. While there is some literature on how previous investigators have solved this problem, no satisfactory criteria emerges for determining who should be included in and excluded from this category. Based on Stein's model (see above, Chapter 2) subjects were simply asked to identify their sexual orientation, and results were interpreted accordingly.

The Silencing the Self Scale (SSS)

The Silencing the Self Scale was used to measure self silencing among participants. Scoring for the SSS and permission to use it are found in Appendix G. The

SSS is a 31-item self-administered questionnaire. Scores range from 0 (least self-silencing) to 155 (most self-silencing). The participant reads a statement and indicates on a five point Lickert scale the extent to which she identifies with that statement. Five items are scored in reverse; i.e., if the participant endorses 1 then it is scored 5; a 2 is scored 4, a 3, 3, a 4, 2, and a 5, a 1. There are four subscales in the SSS:

1. Externalized self-perception (items 6, 7, 23, 27, 28, 31)
2. Care as self-sacrifice (items 1, 3, 4, 9, 10, 11, 12, 22, 29)
3. Silencing the self (items 2, 8, 14, 15, 18, 20, 24, 26, 30)
4. The divided self (items 5, 13, 16, 17, 19, 21, 25)

Including the total score, this scale yields five scores in all.

Psychometric properties of the SSS were determined by using three groups of women. The first, college undergraduates, were construed to be non-depressed. The second group, participants in a pregnancy and health study who had used cocaine during pregnancy, were construed to be mildly depressed. The third group consisted of women in battered women's shelters. These women were construed to be moderately depressed. The BDI scores of these three groups bore out this assumption.

The mean total scores on the SSS were 78.4, 81.8, and 99.9 for the undergraduate sample, the pregnancy and health sample, and the shelter sample, respectively. Internal consistency (alpha) for the overall measure in the undergraduate sample was .86. For the Externalized Self Perception subscale it was .75; for Care as Self-sacrifice, it was .65; for Silencing the Self subscale, .78; and for the Divided Self, .74. For the pregnancy and health study sample, the alpha coefficients were .89, .79, .60, .81, and .83, respectively. For the shelter sample, the alphas were .94, .83, .81, .90, and .78. Jack warns that the care as self-sacrifice scale should be used independently with caution. Test-retest reliability was .88 for undergraduates, .89 for the pregnancy and health sample, and .93 in

the shelter sample. Construct validity was demonstrated by comparing scores on the SSS with scores on the BDI. Undergraduate women's correlation coefficient between SSS scores and BDI scores was .52. In the pregnancy and health study sample, the correlation was .51. The shelter sample's correlation coeffiecient was .50. All correlations were significant. The means for the three groups on the SSS were 78 for students, 82 for the pregnancy and health sample, and 100 for the shelter sample. These means were all significantly different from each other. The subscales, while construed to be theoretically distinct, were highly intercorrelated.

Divergent validity was partially addressed by Koropsak-Berman (1997). She administered the SSS scale, as well as the Beck Depression Inventory to both male (76) and female (100) college students as well as 70 residents of a battered women's shelter (70). She found that while both genders engaged in nearly equal amounts of self-silencing behavior, that self-silencing was related to depression in women, but it was not related to depression in men. In addition, Jack (1991) discusses other theorists that have attempted to delineate distinctions in personality or individual style that relate to depression. Blatt (1974; Blatt, D'Afflittti, & Quinlan, 1976) could not establish a relationship between his "anaclitic" (dependent) or "introjective" (self-critical) personalities and depression. Neither has Beck (1983) met with success in establishing this relationship between his "sociotropy/autonomy" distinction and vulnerability to depression. Jack (1991) offers this explanation of the lack of results:

> Perhaps one reason sex differences do not emerge in these studies is that researchers are not investigating the cognitive schemas most potent for women's depression – the beliefs about the self in intimate relationship. (p. 228)

In addition, she states:

> The Dysfunctional Attitude Scale (Oliver and Baumgart, 1985) is the closest scale theoretically to the empirically derived measure that I have

> developed, the Silencing the Self Scale. Both scales tap attitudes and beliefs associated with depression, but the SSS understands self-negating attitudes to be contained in the traditional female role imperatives, and the sentences in the SSS reflect a hypothesized dynamic of thought associated with the role. . . The DAS is considered to be gender-neutral. (p. 228)

The Beck Depression Inventory (BDI)

The Beck Depression Inventory was used to measure depression in participants. It is a 21 item, self-administered questionnaire, with scores ranging from 0 (no symptoms of depression endorsed) to 63 (all symptoms endorsed at highest severity level). Each of 21 items provides four response choices. The choices are weighted with scores of 0, 1, 2, or 3, from least to most severe. The inventory takes approximately 10 to 15 minutes to complete, and is scored by simply adding up the appropriate weights for the response endorsed for each item. Permission to use the BDI is found in Appendix G.

The Beck Depression Inventory (BDI) was developed because Beck (1967) believed that it would be useful to measure the depth of depression, and to do so easily. He posited that the BDI would provide a wide range of scores and would be relatively sensitive to small changes over time. In his original norming sample of psychiatric inpatients and outpatients, the mean score was 19.6. Patients determined by psychiatric interview to have no depression achieved a mean score of 10.9; those determined to have mild depression achieved a mean score of 18.7; those with moderate depression had a mean score of 25.4, and those with severe depression had a mean on the BDI of 30.0 (Beck, 1967). Gender comparisons were not reported. Beck used split-half reliability to measure consistency and stability, and the Pearson *r* yielded a reliability coefficient of 0.86, and with the Spearman-Brown correction, the coefficient rose to 0.93. Test-retest reliability was performed by administering the BDI in conjunction with a clinical interview on two occasions, six weeks apart, and it was found that changes in psychiatrists' assessments of depression matched changes in BDI score. The alpha

coefficient for 248 outpatients who self-administered the BDI was 0.86 (Beck & Steer, 1984).

The Beck Depression Inventory has been used extensively in both clinical practice and in research (Santor, Zuroff, Ramsay, Cervantes, & Palacios, 1995). Bumberry, Oliver, and McClure (1978) determined the concurrent validity of the Beck Depression Inventory among college students by comparing BDI scores with those assigned by psychiatric interviewers. The correlation coefficient between the scale and the interview was .77. The correlation coefficient fell to .30 when 1-14 days intervened between the administrations of the scale and the interview. This supports Beck's original assertion (1967) that this is a fluid measure sensitive to changes over time. There was no significant gender difference in psychiatric rating of depth of depression. No other gender comparisons were reported. However, this raises questions about what the BDI is measuring. Depression, as described in the DSM-IV, lasts for two weeks or longer; the BDI scores fluctuate in a period of time much shorter than this (APA, 1994).

Gould (1982) examined the psychometric properties of the Beck Depression Inventory. One hundred and eighty five undergraduates, male and female, participated in the investigation. The mean score was 7.58. Gould found that the internal consistency coefficient of the BDI was 0.82. In addition, the measure correlated significantly with three other measures of depressive symptoms, including the Zung Self-Rating Depression Scale (.42), the UCLA Loneliness Scale (.24), and the Rosenberg Self-esteem Scale (.24). Gould (1982) found no statistically significant differences in BDI scores between males and females. Among outpatient adolescents, Ambrosini, Metz, Bianchi, Rabinovich, & Undie (1991) found internal consistency of the BDI to be 0.91. Test-retest reliability was determined to be 0.86 for all cases. The correlation between the BDI and the 17-Item Depression Scale for all cases was 0.70, which reached significance. Further concurrent

validation for the BDI was established with the Depression-Happiness Scale (r = -.75) (Joseph, Lewis, & Olsen, 1996), the Montgomery-Asberg Depression Rating Scale (r=.67) and the Comprehensive Psychological Rating Scale depression subscale (r =.63) (Martinsen, Friis, & Hoffart, 1995) as well as the State-Trait Anxiety Inventory (r =.69), the Nowicki-Strickland Locus of Control Scale (r=.49), and the Personal Attribute Inventory (a measure of self-concept) (r = .35) (Robinson & Kelley, 1996.) Finally, it was found that ratio of positive to negative self-statements and self-esteem can effectively discriminate low, medium, and high scorers on the BDI (Madonna & Philpot, 1996).

Cass's Stage Theory and its measurement

Cass (1979) proposed a model for homosexual identity development which involves six stages of the coming out process. The first stage, Identity Confusion, is marked by a conscious awareness that information about homosexuality is personally relevant. Much turmoil can be experienced in this stage. At the end of this stage, the person is able to say, "I may be homosexual," and experiences a reduction of that turmoil. During stage 2, Identity Comparison, the individual begins to understand that much of the information and values that she has internalized are no longer relevant. She will come out only to selected people and will still "pass" in many circumstances. By the end of the stage, the individual is saying, "I am probably a homosexual." In stage 3, Identity Tolerance, a greater level of commitment to the new identity is observed. The individual comes out to more people in order to reduce isolation, and seeks out more connections with other homosexual persons. Identity Pride, the fourth stage, is a time for growth and deepening of the connections made in stage three. Homosexuality becomes more "normal" to the individual, and she surrounds herself with a peer group that sees things the same way. As the individual experiences homosexuality as more and more acceptable, there is increasing tension with society's disapproval. This leads to stage 5,

Identity Pride, in which there is strong affiliation with groups and activities that affirm homosexual identity, and there may be political activity. In stage 6, Identity Synthesis, there is a realization that formerly firmly entrenched, polarized views may not be true. There is positive acceptance of gay identity, but an understanding that this is merely one facet of a complex individual.

In 1984, Cass developed the Stage Allocation Measure (SAM). This is a self-administered questionnaire, in which six descriptions are provided based on the stages described above. The individual is asked to read each of the descriptions and to endorse the one that she feels most closely describes her and the number of the stage she chooses is the score. Cass analyzed data from 166 participants who used the scale. There were no differences between subjects endorsing any of the six stages and demographic factors.

This measure provides a list of descriptions of types of women. The participant is asked to read each of the stages, and identify the one which most accurately describes her. Cass (1984) examined the relationship between this measure and her Homosexual Identity Questionnaire. This questionnaire was developed by the investigator and listed various characteristics of the six stages that she had theoretically conceived. Participants were asked to endorse one choice each on 210 multiple choice items. Then, participants were asked to endorse the stage on the Stage Allocation Measure that they thought described themselves most appropriately. Questionnaire responses were compared with self-identified stage to determine whether respodents could be categorized accurately with the stage measure. She hypothesized that items designed to tap into the stage the individual is at would be endorsed more frequently than items aimed at other stages.

It was found that individuals at self-identified stages 1, 2, 4, 5, and 6 positively endorsed more items representing that stage than any other stage. For individuals at stages 1, 5, and 6, significance was reached. For individuals at stages 2 and 4 statistical

significance was not reached, but the response pattern was the same. This was not the case for individuals who identified themselves at stage 3; most commonly, they endorsed items identifying stage 2 characteristics. However, those identifying with each stage did endorse items aimed at that stage more than members of any other group at every stage. The author also hypothesized that the farther away an individual is from a given stage, the less items she would endorse for that stage. This was supported strongly by individuals in stages 1, 2, 5, and 6, and less strongly by individuals in stages three and four. A discriminant analysis supported the researcher's assertion that there were in fact six groups, and the percentage of cases correctly classified by the analysis was 97%. For the purpose of this study, women at stages one and two were be removed from consideration as they are neither lesbian nor heterosexual by their own description. It should be noted that this is a one-item scale, and was used as categorical data. Permission to use this measure is found in Appendix G.

Procedures and Data Analysis

Data collection

Participants were recruited as stated earlier. The investigator distributed a packet to each woman that included a letter of explanation acquainting the participant with the study and instructions; an informed consent document; a demographic data form; a copy of the Silencing the Self Scale; and a copy of the Beck Depression Inventory. In addition, there was a copy of the Stage Allocation Measure. The letter directed participants to fill this out only if they believe they are lesbians or are questioning their sexual orientation.

When groups were approached in person, time and space were provided so that respondents completed questionnaires immediately. Participants were not allowed to take packets with them due to restrictions by the Psychological Corporation and the Human

Subjects Committee of West Virginia University. In the first case, the Psychological Corporation does not permit its measures to be sent in the mail. In the second case, the investigator intended to collect names and phone numbers of participants, but the Human Subjects Committee wanted to insure anonymity, due to the sensitive nature of research about sexual orientation. All data were entered into a database in the Statistical Package for the Social Sciences (SPSS). Each packet was uniquely numbered and the number was written on each of the pages within the packet. No identifying information was requested in the packet.

Data analysis

In this study, descriptive statistics, correlations, ANOVAs, regression analyses, Fischer's z-transformations, and a factor analysis were used to obtain results. Correlations were determined for each of the demographic variables, including sexuality, race, SES, presence and number of children, religious affiliation, employment status, education, and partnership status and each of the measures administered (SSS, BDI, and SAM.) This was done to determine whether the sample was preselected for any of these variables. In addition to descriptive statistics and comparison of the lesbian and heterosexual samples, test statistics were employed to answer each of the research questions specified in Chapter 1. Table 1 indicates the analyses used for each question.

Limitations of the study

This investigation did not contain male homosexual and heterosexual reference groups. Sampling was done from groups such as email lists and church groups. Women of low socio-economic status and women of color were underrepresented, thus limiting broad generalizations of results. Data were only gathered from heterosexual and lesbian women; bisexual women were not represented, due to the potential complexities to

analysis. This introduced a potential problem in that it is possible that by this systematic exclusion, some women in early stages of coming out will be excluded. It may be that in some cases women who are in early stages of coming out find the label "bisexual" more tolerable and more congruent with their actual behavior than "lesbian," though they may later go on to identify as lesbian. Related to this issue is that there is no definitive way to determine who is a lesbian and who is not, which may lead to errors in categorization. There were other problems with the measures. The SSS, the BDI, and the SAM all have limitations as discussed above. Some participants did not complete all questions, and all measures were presented in the same order for each participant which may have resulted in ordering effects. There appeared to be a respose set problem on the SSS. In addition, women in stages 1, 2, and 3 of the Stage Allocation Measure were excluded from analysis, as they are neither lesbian nor heterosexual by their own description. Finally, this was not be an exhaustive study of the experience of depression in lesbians; rather, it was an assessment of the fit of one model with that experience.

There are elements of the design of this study that may affect the interpretation of the results of the investigation. Sample sizes of 85 and 71 per group may be too small for accurate estimates of the characteristics of the population under study. In addition, the respondents may not represent the population under study. Middle class women in early and middle adulthood with university educations were overrepresented. In addition, women practicing some religion were probably overrepresented, although how this ultimately affects generalizability is unclear.

Table 1

Reseach Questions and Corresponding Statistical Analyses

Research Question	Type of Data	Analyses
1. A) What are the demographic characteristics of the subjects by total group and by sexual orientation (lesbian and heterosexual women)?	Various data collected from demographic information sheet	Means, standard deviations, percentages, chi squares
B) How representative is the sample compared to census data?	Census data	Means, standard deviations, percentages, chi squares
2. What degree of self-silencing as measured by the Silencing the Self Scale (SSS) is reported for the total sample and for lesbians and heterosexual women and do the groups differ on this measure?	1 total score and 4 subscale scores per subject	Means, standard deviations, ANOVA
3. What degree of depression as measured by the Beck Depression Inventory (BDI) is reported for the total sample, and for lesbians and heterosexual women and do the groups differ on this measure?	1 total score per subject	Means, standard deviations, ANOVA, cut-off point analyses
4. What factors emerge from an analysis of the SSS items and how do they compare with Jack's seminal work?	31 items per subject	factor analysis
5. What is the relationship between the demographic variables of the subjects and scores on the SSS and the BDI?	various data from demographic information sheet	correlations

Table 1 (continued)

Research Question	Type of Data	Analyses
6. Do differences exist between groups in any of the demographic factors and depression and/or self-silencing?	correlation coefficients from above comparisons	Fisher's z-transformation
7. Are there differences between groups or on any demographic variables in the degree to which self-silencing predicts depression?	SSS scores, dummy variables, BDI scores	Hierarchical multiple regression analysis
8. Is stage of coming out as measured by the Stage Allocation Measure related to self-silencing and/or depression in lesbians?	1 score for each of SAM, SSS, and BDI	ANOVA

Chapter 4

Results

The measures used to address the research questions were a demographic data questionnaire (DDQ), the Silencing the Self Scale (SSS), the Beck Depression Inventory (BDI), and the Stage Allocation Measure (SAM). The SSS purports to measure the degree to which people fail to express their experiences in romantic relationships. The BDI is a widely used screening measure for degree of depression and suicide risk. The SAM is a scale that is used to rate individuals on the level of disclosure and comfort with their coming out process.

Research questions 1A and 1B: What are the demographic characteristics of the subjects by total group and by sexual orientation (lesbian and heterosexual women)? How representative is the sample compared to census data? Frequencies and percentages of demographic characteristics were computed and are described below.

The frequencies and percentages of demographic characteristics of the participants are presented in Table 2. A total of 170 women participated in this study. Of the participants, 85 were lesbians, 71 were heterosexual, and 14 were bisexual. Participants were predominantly white (91%), with some racial diversity among the remaining participants. Three percent were African-American, 2.5% were Latina, 2.5% were Asian/pacific islander, and less than one percent was “other.” Two participants did not identify their races. Table 3 compares the ethnicity of the members of this sample

Table 2

Demographic Characteristics of the Participants (N=170), Frequencies and Percentages

	Frequency	Percent
Sexual Orientation		
Lesbian	85	50
Heterosexual	71	42
Bisexual	14	8
Ethnicity		
Caucasian	154	91
African-American	5	3
Hispanic/Latina	4	2.5
Asian/PI	4	2.5
Native American	0	0
Other	1	1
Did not identify	2	1
Committed Relationship		
Yes	119	70
No	51	30
Married		
Yes	53	31
No	117	69

Table 2 (continued)

	Frequency	Percent
Children		
Yes	51	30
No	119	70
Household Income		
< $15,000	31	18.2
$15,000 - $25,000	25	14.7
$25,000 - $35,000	17	10
$35,000 - $45,000	23	13.5
$45,000 - $60,000	24	14.1
$60,000 - $80,000	22	12.9
$80,000 - $100,000	17	10
> $100,000	9	5.3
Did not report	2	1.1
Educational level		
Some high school	0	0
H S diploma or equivalency	5	2.9
Trade school graduate	0	0
Some college	20	11.8
Associate's Degree	13	7.6

Table 2 (continued)

	Frequency	Percent
Bachelor's Degree	70	41.2
Master's Degree	46	27.0
Doctoral Degree	16	9.4
Practice religion		
Yes	98	57.6
No	72	42.4
Counseling or psychotherapy		
Yes	32	18.8
No	138	81.2
Medication		
Yes	27	17.3
No	129	82.7
Non-traditional treatments for psychiatric symptoms		
Yes	23	14.7
No	143	85.3

Table 3

Percentage Comparison of Ethnic Characteristics of Participants with Local and Federal US Census Data (2000 Census)

	Participants	RI[a,b]	PA[a,b]	WV[a,b]	US[b]
Ethnic Group					
White	91	78.4	84.3	92.2	75.1
African American	3	6.5	12.4	3.4	12.3
Latina	2.5	13.4	0.9	1.0	12.5
Asian/PI	2.5	2.9	1.7	2.5	3.7
Other	1	0.6	1.5	0.5	6.4

a – census data is drawn from the counties in which the data were collected, as in all three cases the counties in which the data were collected were more diverse than the state as a whole. Counties used were Providence County, RI; Allegheny County, PA; Monongalia County, WV.

b – In all four cases the percentages exceed 100. As these data are supposed to only represent individuals who report belonging to one race, it is unclear why this would be so.

to the ethnicities of the states in which data were collected, as well as national data. Census data were only available for comparison for ethnicity. Despite efforts to recruit participants from minority groups, the participants in this investigation were less diverse than the populations of Providence County, RI, and Allegheny County, PA. The participants were more diverse than the residents of Monongalia County, WV. The ethnic composition of this group largely does not reflect local or national figures.

Subjects ranged in age from 19 years to 60 years, with a mean of 35.9 years (*SD*=10.6). (Age is reported by group in Table 8.) The age of participants did not differ significantly between groups ($F(1,154)=1.925$, p=.167). Most subjects reported being currently involved in a committed romantic relationship (70%). However, most reported they were not married (31% were married.) Thirty percent reported having children. Annual household income varied widely. Most of the group held either a bachelor's degree or a master's degree (n=116). In addition, most of the group practiced some form of religion (57.6%).

Subjects were asked to identify their current religious affiliation. They were also asked to identify the religious tradition in which they were raised. Results are reported in Table 4. Table 5 compares religions of participants in this investigation with the populations of Providence County, RI, Allegheny County, PA, and Monongalia County, WV, and with the overall United States population. The comparison data are from the American Religion Data Archive.

Results of questions asked regarding relationships, ethnicity, marital status, parenthood, household income, education, religion, counseling or psychotherapy,

Table 4

Frequency of religions of participants (n=170)

	Current	Upbringing
None/nonpracticing	71	33
Catholic	30	71
Episcopalian	27	10
Other traditional Protestant	27	43
Unitarian Universalist	12	0
Jewish	3	5
Islam	2	1
Spiritual	2	0
Hindu	1	1
Eastern Orthodox	1	0
Buddhist	1	0
Russian Orthodox	0	1
Greek Orthodox	0	1
LDS	0	1
Pentecostal	0	1
Seventh Day Adventist	0	1

Table 5

Percent of sample representing religious denominations and comparison with counties in which data were collected and US data

	Sample Percent	RI %	PA %	WV %	US %
None/nonpracticing	37.6	a	a	a	a
Catholic	17.6	71.0	48.0	11.2	21.4
Episcopalian	15.9	2.4	1.1	<1.0	1.0
Other traditional Protestant	15.9	*	*	*	*
Unitarian Universalist	7.0	<1.0	<1.0	<1.0	<1.0
Jewish	1.8	1.7	2.0	<1.0	2.4
Islam	1.2	*	*	*	*
Spiritual	1.2	*	*	*	*
Hindu	0.6	*	*	*	*
Eastern Orthodox	0.6	*	<1.0	*	<1.0
Buddhist	0.6	*	*	*	*

* Data are not available

a – The American Religious Data Archive reports individuals who are “not claimed” by a church. This is thought not to be analogous to “no religion” or “not practicing” so these data were not included.

Table 6

Demographic Characteristics of the Participants by Sexual Orientation (N=170), Frequencies and Percentages

	Lesbian		Heterosexual		Bisexual	
	F	%	F	%	F	%
n[a]	85	50.0	71	42.0	14	8.0
Ethnicity[b]						
White	79	92.9	62	87.3	13	92.9
African-American	4	4.7	1	1.4	0	0
Latina	2	2.3	2	2.8	0	0
Asian/PI	0	0	3	4.2	1	7.1
Other	0	0	1	1.4	0	0
Did not identify	0	0	2	2.8	0	0
Committed Relationship[b]						
Yes	28	33.0	55	77.5	7	50.0
No	57	67.0	16	22.5	7	50.0
Married[b]						
Yes	19	22.3	30	42.2	5	35.7
No	66	77.7	41	57.8	9	64.3
Children[b]						
Yes	17	20.0	32	45.1	2	14.3
No	68	80.0	39	54.9	12	85.7

Table 6 (continued)

	Lesbian		Heterosexual		Bisexual	
	F	%	F	%	F	%
Household Income[b]						
< $15,000	10	11.8	18	25.4	3	21.4
$15,000 - $25,000	9	10.6	12	16.9	4	28.6
$25,000 - $35,000	12	14.1	4	5.6	1	7.1
$35,000 - $45,000	15	17.6	7	9.9	1	7.1
$45,000 - $60,000	11	12.9	11	15.5	2	14.3
$60,000 - $80,000	10	11.8	10	14.1	2	14.3
$80,000 - $100,000	11	12.9	5	7.0	1	7.1
>$100,000	7	8.2	2	2.8	0	0
Did not report	0	0	2	2.8	0	0
Educational Level[b]						
Some high school	0	0	0	0	0	0
HS diploma/equiv	4	4.7	1	1.4	0	0
Trade school graduate	0	0	0	0	0	0
Some college	15	17.6	5	7.0	0	0
Associate's Degree	5	5.9	6	8.5	2	14.3
Bachelor's Degree	28	32.9	35	49.3	7	50.0
Master's Degree	21	24.7	21	29.6	4	28.6
Doctoral Degree	12	14.1	3	4.2	1	7.1

Table 6 (continued)

	Lesbian		Heterosexual		Bisexual	
	F	%	F	%	F	%
Practice religion[b]						
Yes	44	51.8	47	66.2	7	50.0
No	41	48.2	24	33.8	7	50.0
Counseling or psychotherapy[b]						
Yes	23	27.1	6	8.5	3	21.4
No	62	72.9	65	91.5	11	78.6
Psychiatric medications[b]						
Yes	16	18.8	11	15.5	3	21.4
No	69	81.2	60	84.5	11	78.6
Nontraditional treatments for psychiatric symptoms[b]						
Yes	13	15.3	10	14.8	4	28.7
No	72	84.7	61	85.2	10	71.3

a – percentages represent proportion of total sample

b – percentages represent proportion of sexual orientation group

psychiatric medications, and other psychological treatment, are shown by group in Table 6. Heterosexual women were the most diverse group, with 13% of the group representing minority women. Seven percent of the lesbian group was minority women. Chi square analyses of demographic data are presented in Table 7, and ANOVA data are presented in Table 8. Bisexual women have been excluded from this and further analysis except where indicated because of the low number of participants in that group and because of the theoretical complexity that they present for this study. Heterosexual women and lesbians were equally likely to be in a committed relationship (F(1, 156)= 2.069; p=. .319) Heterosexual women's relationships were significantly longer than lesbians' (F(1, 110)= 10.47; p=. 002) as were their marriages (F(1, 47) =13.61; p=.007). Lesbians were significantly less likely to be married or have children (χ^2(1, N =156) = 7.111, p =. 006; χ^2(1, N = 156) = 11.286, p=.001), but the ages of the children were not different between the groups (F(1,42) = 0.744; p=0.210) Lesbians were significantly more likely to be in counseling or psychotherapy (χ^2(1, N=156) = 8.850, p=. 002), but the groups were equally likely to be taking psychiatric medications or to be using non-traditional treatments for symptoms of depression or anxiety (χ^2(1, N = 156) = 0.162, p=. 109).

The two groups did not differ in age (F(1,154) = 1.925, p=. 167) or in educational achievement (F(1,154) = 0.627, p=. 430); however lesbians had significantly higher household incomes than heterosexual women (F(1,154) = 6.253, p=. 013). Participants' spouses' educational levels did not differ either (F(1,110) = 0.002, p=. 967). Education was measured on an ordinal scale with some high school having a value of 1 and achievement of a doctoral degree having a value of 8. Lesbians were significantly less

Table 7

Chi square analyses for group membership (independent variable) and various demographic characteristics; means and standard deviations of dummy variables (n=156)

Dependent Variable	Lesbian		Heterosexual				
	X	SD	X	SD	df	N	χ^2
Counseling or Psychotherapy	0.27	0.45	0.01	0.28	1	156	8.850**
Psychiatric Treatment	0.39	0.49	0.28	0.45	1	156	0.162
Practice religion	0.52	0.50	0.66	0.48	1	156	3.315*
Married	0.22	0.42	0.42	0.50	1	156	7.111**
Committed Relationship	0.61	0.49	0.69	0.47	1	156	2.069
Children	0.20	0.40	0.45	0.50	1	156	11.286**

*p<.05; ** p< .01

Table 8

Analyses of variance for group membership (independent variable) and various demographic characteristics

Dependent Variable	Lesbian		Heterosexual			
	X	SD	X	SD	df	F
Age	37.18	9.92	34.80	11.44	1,154	1.925
Length of Relationship	4.50	4.68	9.00	9.25	1,110	10.47**
Length of Marriage	4.29	4.30	12.65	9.20	1, 47	13.61**
Age of children	12.03	9.37	14.56	9.97	1, 42	0.744
Education	5.93	1.53	6.10	1.03	1, 154	0.627
Household income	4.38	2.15	3.49	2.25	1, 154	6.253*
Spouses' Education	4.40	2.80	4.38	2.69	1, 110	0.002

*p<.05; ** p< .01

likely to practice a religion than their heterosexual counterparts ($\chi^2(1, N = 156) = 3.316$, p=. 048).

As several consecutive chi square analyses and ANOVAs were performed, there was concern about potential Type I error. Bonferroni's adjustment technique was used to assure that the accumulated alpha level did not exceed the acceptable .05 cutoff. The sum of the p values of the four significant chi-square tests was in these analyses was equal to .057. However, one analysis, practicing religion, was responsible for .048 of the .057. If this is removed from consideration, the accumulated alpha was equal to .009, well below the accepted .05 level. Thus appropriate care should be taken in interpreting results. Among the ANOVAs performed, the accumulated alpha for the significant tests was .022, also well below the accepted .05 level.

Participants were asked to rate the amount of support they experienced from family, friends, spouse, religious community and community on a scale of 1 through 7. One indicated no support and seven indicated as much as needed. These data are presented in Table 9. One-way analyses of variances (ANOVA) demonstrated the groups did not differ in their perceived amount of support from families or from their communities. Heterosexual women felt they had significantly more support from their religious communities ($F(1,156) = 4.139$, p=. 018). Lesbians felt they had significantly more support from their spouses and friends ($F(1,110) = 9.434$, p=. 005; $F(1,156) = 7.233$, p=. 001). The cumulative alpha level reached was .024, which is below the acceptable .05 cutoff.

Table 9

Analyses of Variance for Group Membership (independent variable) and Perceived Social Support

	Lesbian		Heterosexual		Total			
	X	SD	X	SD	X	SD	df	F
Family support	5.21	1.88	5.55	1.79	5.39	1.83	1, 154	.806
Support of friends	6.33	1.11	5.58	1.37	5.98	1.28	1, 154	7.233**
Support of spouse	6.58	0.75	5.91	1.46	6.25	1.20	1, 110	9.434**
Support from religious community	2.22	2.66	3.39	2.60	2.71	2.69	1, 154	4.139*
Community support	4.32	1.98	3.87	1.88	4.16	1.93	1, 154	1.521

* p<.05; **p<.01

Research question 2: What degree of self-silencing as measured by the Silencing the Self Scale (SSS) is reported for the total sample and for lesbians and heterosexual women and do the groups differ on this measure? Means, standard deviations, and ANOVAs, were performed to provide descriptive data and significance tests.

The means and standard deviations on the SSS for the group as a whole as well as by sexual orientation are listed in Table 10. Overall, there was little problem with missing data on this measure. Only two participants were omitted from analysis because they were thought to have too much missing data (>15% of items omitted.) However, observation of the raw data led to a concern about the reverse scored items. There are only 5 reverse-scored items, and it was observed that respondents tended to confine answers to one end of the scale. It seemed that there was a response set among some participants, so care should be taken in interpreting results. Adding to this problem was the fact that the investigator failed to repeat the scale at the top of each of the four pages, so it seemed that participants sometimes became confused toward the end.

Lesbians scored higher than heterosexual women on the total measure and on every subscale. One-way ANOVAs were performed to determine whether differences between groups were significant. While the groups scored significantly differently on the measure as a whole ($F(1,154) = 4.262$, p=. 041), significance was only reached on the Silencing the Self (STS) subscale ($F(1,154) = 10.350$, p=. 002). There were no significant differences on the Externalized Self-perception, Care as Self-sacrifice, and Divided Self subscales ($F(1,154) = .157$, p=. 692; $F(1,154) = 3.384$, p= .068; $F(1,154) = .949$, p= .331, respectively).

Research question 3: What degree of depression as measured by the Beck Depression Inventory (BDI) is reported for the total sample, and for lesbians and heterosexual

women and do the groups differ on this measure? Means, standard deviations, and ANOVAs were performed to provide descriptive statistics as well as tests of significance.

The results on the BDI for the group as a whole as well as by sexual orientation are presented in Table 10. The group mean for the measure was 7.5 and the standard deviation was 6.5. The means for the lesbian and heterosexual group were 8.0 and 6.9 respectively. None of these scores reached the cutoff score of 10, which indicates depression on the BDI. There was a significant problem with missing data on this measure. The measure had a front and a back, and 11 participants did not complete the reverse side of the measure. These were the only participants who did not complete more than 85 % of the measure. It was decided that since this was such a large group, a one-way ANOVA, conducted to discern whether there were differences between the groups on BDI scores, would be performed on the 145 participants who completed the measure. The ANOVA failed to demonstrated a difference in depression between lesbian and heterosexual participants ($F(1,143)=1.012$, p= .316). These 11 participants were omitted from all further analyses that included the BDI.

Research question 4: What factors emerge from an analysis of the SSS items, and how do they compare with Jack's seminal work? A factor analysis of SSS items was performed.

Results of a factor analysis with varimax rotation conducted on all the items of the Silencing the Self Scale are shown in Table 11. The correlation matrix for the factor analysis is shown in Table 12. Seven factors were produced. The first factor collapsed the Divided Self subscale and the Externalized Self-perception subscale that emerged in

Table 10

Silencing the Self Scale Scores and Beck Depression Inventory Means and Standard Deviations (n=156)

	Lesbian		Heterosexual		Total			
	X	*SD*	X	*SD*	X	*SD*	df	F
SSS Total	77.9	22.0	71.0	19.0	74.7	20.9	1, 154	4.262*
Subscale 1 ESP	13.56	5.04	13.26	4.42	13.43	4.76	1, 154	0.157
Subscale 2 CSS	23.05	6.38	21.27	5.59	22.24	6.08	1, 154	3.384
Subscale 3 STS	22.35	7.68	18.67	6.40	20.68	7.34	1, 154	10.35**
Subscale 4 DS	15.97	6.77	14.93	6.47	15.5	6.63	1, 154	0.949
BDI Total	8.0	7.3	6.9	5.4	7.5	6.5	1, 143	1.012

* p<.05; **p<.01

Table 11

Results from factor analysis with varimax rotation for Silencing the Self Scale Items

Factors	1	2	3	4	5	6	7
6	**.713**	.192	-.002	.059	-.082	.021	-.002
7	**.631**	-.023	.257	.231	-.035	-.067	-.160
13	**.502**	.477	.070	.206	-.028	.069	.116
16	**.517**	.167	.350	.253	.114	.071	-.088
17	**.558**	.243	.102	.439	.095	-.150	.066
19	**.564**	.272	.185	.310	.033	.044	-.057
27	**.761**	.097	-.021	-.121	.291	.059	.115
28	**.696**	.204	.110	.054	.207	.293	-.067
31	**.634**	.146	.286	.002	.175	-.156	-.232
2	.079	**.672**	.225	.262	.005	-.018	-.132
5	.399	**.432**	.101	.322	-.159	-.026	-.126
14	.307	**.770**	.203	.006	.063	.102	.114
18	.449	**.465**	.279	.328	.017	.002	.033
24	.133	**.685**	.081	-.090	.206	.063	-.068
26	.289	**.640**	.239	.289	.085	.028	.167
30	.499	**.543**	.343	.103	-.096	.102	.072
3	.085	.085	**.764**	-.052	.158	.070	.056
4	.070	.202	**.655**	.303	.184	.150	.023
9	.091	.174	**.718**	-.248	.267	.110	-.085
10	.127	.097	**.707**	.043	-.225	-.104	.190
20	.355	.262	**.435**	.225	.182	.017	.292
29	.259	.274	**.539**	.029	.121	.242	-.079
15	-.065	.432	-.020	**.528**	.102	.124	-.143
21	.239	.016	.007	**.730**	.063	.120	-.064
25	.530	.224	-.098	**.573**	.075	.003	-.106
12	.192	.098	.184	-.011	**.627**	-.049	.420
22	.122	.125	.291	.289	**.733**	.024	-.171
8	.121	.415	-.016	-.008	.136	**.586**	-.168
11	-.172	-.182	.248	.174	-.118	**.675**	.274
23	.385	.322	.277	.128	-.055	**.464**	-.095
1	-.167	-.029	.068	-.163	.019	.018	**.742**

Bolded numbers indicate the highest loading for that item

Table 12

Correlational Matrix for Factor Analysis of Silencing the Self Scale Items

	Item													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1	1.000													
2	-.088	1.000												
3	.145	.224	1.000											
4	.017	.349	.463	1.000										
5	-.200	.408	.167	.273	1.000									
6	-.171	.217	.070	.179	.373	1.000								
7	-.178	.174	.197	.259	.353	.482	1.000							
8	-.066	.262	.106	.214	.225	.183	.106	1.000						
9	.002	.183	.603	.450	.112	.098	.166	.188	1.000					
10	.150	.200	.427	.375	.131	.126	.176	.024	.373	1.000				
11	.105	-.012	.175	.176	-.033	-.112	-.066	.061	.145	.063	1.000			
12	.132	.117	.259	.252	.043	.164	.136	.062	.268	.142	.051	1.000		
13	-.045	.408	.208	.259	.516	.431	.354	.290	.168	.169	-.052	.153	1.000	
14	-.082	.482	.276	.316	.433	.337	.226	.369	.322	.239	.002	.271	.473	1.000
15	-.109	.356	.024	.254	.258	.136	.128	.240	-.007	.018	.012	-.022	.260	.308
16	-.118	.345	.276	.335	.275	.327	.426	.224	.318	.302	.005	.151	.334	.362
17	-.144	.281	.192	.259	.435	.424	.441	.130	.090	.161	-.086	.156	.463	.430
18	-.199	.434	.225	.370	.409	.393	.391	.298	.294	.286	-.019	.264	.501	.580
19	-.163	.329	.209	.314	.458	.371	.366	.139	.183	.208	-.007	.160	.558	.406
20	.016	.277	.335	.500	.329	.287	.309	.176	.362	.302	.095	.332	.401	.455
21	-.197	.231	.066	.198	.301	.209	.292	.140	-.073	.099	.062	.078	.250	.121
22	-.100	.238	.293	.418	.188	.115	.235	.174	.329	.117	-.018	.368	.212	.221
23	-.063	.371	.273	.431	.344	.344	.347	.318	.197	.224	.167	.097	.386	.402
24	-.026	.414	.201	.181	.303	.203	.132	.228	.268	.101	-.052	.172	.339	.530
25	-.199	.351	.015	.171	.492	.424	.383	.190	-.048	.033	-.100	.081	.429	.297
26	-.015	.532	.213	.414	.354	.348	.292	.273	.276	.261	-.008	.223	.467	.642
27	-.037	.104	.146	.129	.270	.466	.358	.116	.182	.060	-.116	.262	.400	.348
28	-.122	.295	.191	.226	.310	.424	.328	.331	.247	.216	-.047	.216	.438	.415
29	-.067	.301	.446	.407	.202	.200	.263	.253	.431	.383	.141	.173	.311	.431
30	-.099	.441	.285	.398	.483	.472	.409	.272	.311	.368	.040	.238	.442	.683
31	-.130	.359	.272	.285	.353	.401	.479	.115	.251	.181	-.181	.220	329	.293

Table 12 (continued)

Items

	15	16	17	18	19	20	21	22	23	24	25	26	27	28
15	1.000													
16	.279	1.000												
17	.211	.427	1.000											
18	.299	.505	.563	1.000										
19	.296	.499	.408	.517	1.000									
20	.156	.429	.413	.531	.351	1.000								
21	.305	.309	.342	.327	.323	.196	1.000							
22	.255	.301	.325	.244	.276	.334	.213	1.000						
23	.196	.344	.274	.398	.391	.324	.202	.261	1.000					
24	.187	.204	.235	.304	.270	.205	.145	.261	.366	1.000				
25	.241	.381	.653	.465	.506	.243	.531	.305	.372	.259	1.000			
26	.366	.473	.461	.561	.451	.498	.269	.304	.416	.405	.413	1.000		
27	.046	.430	.393	.292	.426	.336	.166	.236	.225	.255	.313	.304	1.000	
28	.201	.534	.434	.459	.510	.358	.276	.315	.496	.230	.453	.398	.588	1.000
29	.126	.344	.315	.384	.341	.383	.169	.330	.377	.340	.260	.406	.278	.376
30	.266	.476	.438	.602	.482	.485	.246	.206	.504	.414	.355	.604	.381	.502
31	.091	.453	.385	.395	.487	.351	.154	.311	.360	.231	.369	.296	.443	.504

Items

	29	30	31
29	1.000		
30	.456	1.000	
31	.300	.451	1.000

Jack's analysis. This factor accounted for 16.7% of the variance. The second factor was much like Jack's Silencing the Self subscale, and accounted for 12.6% of the variance. The third factor mirrored Jack's Care as Self-sacrifice subscale, and accounted for 11.2% of the variance. The remaining four scales yielded no discernable pattern when compared with Jack's results. The fourth, fifth, sixth, and seventh scales accounted for 7.6%, 4.8%, 4.3%, and 4.0% of the variance respectively. One of these four scales contained three items, two of which were reverse-scored items. The solution accounted for a total of 61.3% of the variance.

Research question 5: What is the relationship between the demographic variables of the subjects and scores on the SSS and the BDI? Correlations between demographic variables and scores on the SSS and the BDI were performed, as well as the STS subscale of the SSS, as this subscale was the only one that differed between groups.

The correlational matrix for demographic factors and scores on the SSS and the BDI are presented in Table 13. There were numerous significant correlations, but apart from intercorrelations between measures, all were modest relationships. Significant findings include an inverse relationship between SSS scores and being in a committed relationship (r = -.286)as well as SSS scores and being married (r = -.185). Scores on the BDI were associated inversely with being in a committed relationship (r = -.119). Higher scores on both the BDI and the SSS were directly associated with being in treatment for psychiatric or psychological problems(r = .277; r = .282). Finally, scores on the SSS and BDI themselves were highly correlated (r = .514). This correlation between measures parallels Jack's and Dill's original findings (1992). Significant correlates with STS were the same as the SSS; sexual orientation (r = .258), marital status (r = -.167), committed

Table 13

Correlations for demographic variables and SSS and BDI scores (n=145)

	Age	SO	Married	ComRel	Kids	PrimCar	Income	Educ	Relig	#kids	TX
SSS	.025	.162	-.185*	-.286**	-.152	-.103	.005	-.126	-.122	-.088	.282**
BDI	-.002	.084	-.056	-.119*	-.068	-.014	.006	-.060	-.034	-.029	.277**
STS	.173*	.258**	-.167*	-.252**	-.118	-.124	.061	-.078	-.038	-.089	.305**

	SSS	STS
BDI	.514**	.450**
STS	.880**	1.000

Key

Age – Age in years at last birthday; SO – sexual orientation: 0=heterosexual, 1=lesbian; Married: 0=no, 1=yes; ComRel – committed relationship: 0=no, 1=yes; Kids – presence of children: 0=no, 1=yes; PrimCar – primary caregiver; 0=no, 1=yes; Income – Household income; Educ – Educational level; Relig – Practice religion: 0=no, 1=yes; #kids – Number of children; TX – In treatment for psychological or psychiatric problems: 0=no, 1=yes; SSS – Total score on SSS; BDI – Total score on BDI; STS – Score on Silencing the Self subscale of SSS.

relationship (r = -.252), being in treatment for psychiatric and psychological problems (r = .305), and the BDI (r = .450). Additionally, there was a significant but modest correlation between STS score and age (r = .173).

Research question 6: Do differences exist between groups on any of the relationships between the demographic factors and depression and/or self-silencing? Fisher's Z-transformations were performed and z-scores were computed to compare the correlations of demographic measures and scores on the SSS and the BDI between sexual orientation groups.

Correlations between demographic variables were performed by sexual orientation group and the results are presented in Tables 14 and 15. Demographic variables were selected for significant correlations between demographic factors used in question 5 for either sexual orientation. Results of the z-transformations are reported in Table 16. There were six correlations that differed significantly between lesbians and heterosexual women. Among lesbians, age was directly related to SSS scores (older women were more self-silenced) while among heterosexual women older women were less self silenced. Both correlations were significant and they were significantly different from each other (r_l = -.236; r_h = .270; z_r = -3.07). Having children was inversely related to SSS scores in lesbians, while it was a direct relationship in heterosexual women: this difference was significant (r_l = -.304; r_h = .078; z_r = -2.30).

It was found that there is a stronger relationship between perceived community support and score on SSS among lesbians, and that this relationship is an inverse one (r_l = -.375; r_h = .047; z_r = - 2.65). Household income and educational levels were more strongly related to SSS scores among lesbians than among heterosexual women; these

Table 14

Correlation matrix for demographic variables, SSS, and BDI scores for heterosexual subjects (n=69)

	Age	Mar	CR	Kids	Number	PC	HI	EL	Help	PR	FS
Age	1.000										
Mar	.399**	1.000									
CR	.028	.375**	1.000								
Kids	.640**	.559**	.180	1.000							
Number	.597**	.421**	.074	.877**	1.000						
PC	.345**	.543**	.154	.783**	.657**	1.000					
HI	.499**	.551**	.271*	.488**	.420**	.439**	1.000				
EL	.103	.061	.097	-.032	-.044	.079	.305*	1.000			
Help	.381**	.689**	.315**	.750**	.642**	.822**	.494**	.206	1.000		
PR	.190	.209	.044	.144	.146	.043	.069	-.020	.060	1.000	
FS	-.209	-.136	.020	-.306*	-.258*	-.253*	-.291*	-.232	-.262*	.098	1.000
SF	.092	-.061	-.103	.031	.125	-.112	-.004	-.091	-.077	.335**	.308**
RC	.135	.046	-.058	.041	.062	.004	-.162	-.126	-.041	.721**	.270*
CS	.080	-.071	.008	-.094	.000	-.087	-.235	.008	-.107	.267*	.397**
TX	.153	-.008	-.043	.129	.177	.158	.061	.276*	.249*	.045	-.074
POC	.052	-.150	-.230*	-.072	-.041	.000	.055	.317**	-.020	.000	-.001
MEDD	.302*	.211	-.182	.276*	.266*	.373*	.106	.291*	.302*	.034	-.069
MEDA	.025	.016	.024	-.014	-.076	-.034	.213	.245*	.037	-.068	.039
TOTSC	.270*	-.161	-.206	.078	.095	.053	.205	.230	-.012	-.258	-.081
TOT	.102	.047	-.094	.091	.073	.210	.111	.100	.210	-.214	-.349**

Table 14 (continued)

	SF	RC	CS	TX	POC	MEDD	MEDA	TOTSC	TOT
SF	1.000								
RC	.402**	1.000							
CS	.511**	.568**	1.000						
TX	-.030	.058	.037	1.000					
POC	-.015	-.035	.136	.483**	1.000				
MEDD	.106	.088	.156	.526**	.407**	1.000			
MEDA	.106	.051	.054	.526**	.407**	.364**	1.000		
TOTSC	-.081	-.181	.047	.169	.342**	.160	.080	1.000	
TOT	-.276*	-.314**	-.120	.311**	.253*	.236	.066	.429**	1.000

* significant at .05 level

** significant at .01 level

Key

Age – Age in years at last birthday; SO – sexual orientation: 0=heterosexual, 1=lesbian; Mar – Married: 0=no, 1=yes; CR – committed relationship: 0=no, 1=yes; Kids – presence of children: 0=no, 1=yes; PC – primary caregiver: 0=no, 1=yes; HI – Household income; EL – Educational level; PR – Practice religion: 0=no, 1=yes; NUM – Number of children TX – In treatment for psychological or psychiatric problems: 0=no, 1=yes; TOTSC – Total score on SSS; TOT – Total score on BDI; FS – family support; SF – support from friends; RC – support from religious community; CS – support from community; TX – in treatment for psychiatric or psychological problems: 0=no, 1=yes; POC – psychotherapy or counseling:0=no, 1=yes; MEDD – taking medication for depression: 0=no, 1=yes; MEDA – taking medication for anxiety: 0=no, 1=yes

Table 15

Correlation matrix for demographic variables, SSS, and BDI scores for lesbian subjects (n=76)

	Age	Mar	CR	Kids	#Kids	PC	HI	EL	Help	PR	FS
Age	1.000										
Mar	.024	1.000									
CR	-.167	.387**	1.000								
Kids	.156	.424**	.333**	1.000							
#Kids	.106	.456**	.277*	.858**	1.000						
PC	-.096	.358**	.257*	.642**	.544**	1.000					
HI	.356**	.272*	.180	.207	.174	.047	1.000				
EL	.347**	.105	-.011	.109	.150	.011	.482**	1.000			
Help	-.040	.498**	.291*	.843**	.841**	.785**	.124	.203	1.000		
PR	.133	.266**	.064	.259*	.295*	.203	.104	-.014	.307**	1.000	
FS	.009	.017	-.049	.006	.011	.011	.054	.187	.064	-.221	1.000
SF	.122	-.049	.001	.037	-.041	-.070	.097	.168	.015	-.080	.261*
RC	.161	.348**	.170	.314**	.407**	.301**	.084	.188	.426**	.776**	.015
CS	-.105	.020	.066	.113	.124	.094	-.137	.207	.199	.121	.274*
TX	.045	-.070	-.339**	-.036	-.076	-.164	.053	-.074	-.106	.152	-.100
POC	.028	.018	-.190	-.040	-.031	-.190	.039	-.111	-.083	.133	.009
MEDD	.087	.098	-.167	-.131	-.050	-.138	-.020	-.045	-.073	.255*	-.053
MEDA	.197	.181	-.163	-.043	-.064	.075	.221	-.126	.024	.173	-.171
TOTSC	-.236*	-.163	-.331**	-.247*	-.212	-.208	-.220	-.249*	-.238*	.011	-.225
TOT	-.103	-.113	-.127	-.136	-.085	-.182	-.093	-.204	-.172	.098	-.183

Table 15 (continued)

	SF	RC	CS	TX	POC	MEDD	MEDA	TOTSC	TOT
SF	1.000								
RC	.018	1.000							
CS	.216	.365**	1.000						
TX	-.080	-.009	-.106	1.000					
POC	-.069	-.040	-.213	.740**	1.000				
MEDD	-.191	.095	-.021	.536**	.315**	1.000			
MEDA	.038	-.109	-.185	.363**	.268**	.275*	1.000		
TOTSC	-.191	-.197	-.375**	.342**	.305**	.064	.117	1.000	
TOT	-.210	-.087	-.266*	.249*	.179	.212	.053	.557**	1.000

* significant at .05 level

** significant at .01 level

Key
Age – Age in years at last birthday; SO – sexual orientation: 0=heterosexual, 1=lesbian; Mar – Married: 0=no, 1=yes; CR – committed relationship: 0=no, 1=yes; Kids – presence of children: 0=no, 1=yes; PC – primary caregiver: 0=no, 1=yes; HI – Household income; EL – Educational level; PR – Practice religion: 0=no, 1=yes; NUM – Number of children;TX – In treatment for psychological or psychiatric problems: 0=no, 1=yes; TOTSC – Total score on SSS; TOT – Total score on BDI; FS – family support; SF – support from friends; RC – support from religious community; CS – support from community; TX – in treatment for psychiatric or psychological problems: 0=no, 1=yes; POC – psychotherapy or counseling:0=no, 1=yes; MEDD – taking medication for depression: 0=no, 1=yes; MEDA – taking medication for anxiety: 0=no, 1=yes

Table 16

Comparison of correlation coefficients of heterosexual and lesbian women on selected demographic variables and scores on SSS and BDI (n=145)

	SSS			BDI		
	Lesbian	Heterosexual	Z_r[a]	Lesbian	Heterosexual	Z_r[a]
Age	-.236	.270	3.07**	-.103	.102	1.18
ComRel	-.331	-.206	0.76	-.127	-.094	-1.30
Married	-.163	-.161	0.00	-.113	.047	0.94
Kids	-.304	.078	2.30**	-.165	.091	-1.54
#kids	-.212	.095	1.84	-.085	.073	-0.12
Help	-.238	-.012	1.38	-.172	.210	2.36**
Income	-.220	.205	2.51**	-.098	.111	1.23
Educ	-.311	.230	3.27**	-.129	.100	1.36
Relig	.011	-.258	-1.63	.098	-.214	-1.84
FamSup	-.225	-.081	0.91	-.183	-.349	1.08
Friends	-.191	-.054	0.83	-.210	-.276	0.44
RelCom	-.197	-.181	0.09	-.087	-.314	1.36
ComSup	-.375	.047	2.65**	-.266	-.120	0.92
Therapy	.305	.342	-0.22	.179	.253	-0.43
TX	.342	.169	1.07	.249	.311	0.39

* p<.05; **p<.01

Table 16 continued
ComRel – Committed Relationship; Married -- Married; kids – presence of children; #kids – number of children; help – perceived helpfulness of spouse; income – household income; educ – educational level; relig – practice religion; FamSup – family support; Friends – Support of friends; RelCom – Support of religious community; ComSup – Community Support; TX – in treatment for psychiatric or psychological problems.

had children (n = 49; 17 lesbians and 32 heterosexual women had children). The finding held with this second analysis (r_l = -.159; r_h = .314; z_r = -2.94).

Research question 7: Are there differences between groups or on any demographic variables in the degree to which self-silencing predicts depression? Cumulative R^2 each variable was brought in on a separate forward step. A hierarchical multiple regression analysis was performed to determine whether any variables for which data were collected contributed to the degree to which self-silencing predicts depression.

Significant models from the regression analysis are presented in Table 17. The cumulative F value was 12.827 (p<.001). Cumulative R was .562 and cumulative R^2 was .316. Predictor variables put into the analysis were committed relationship status, having children, educational level, household income, perceived support, being in treatment, sexual orientation, and scores on the Silencing the Self Scale. The criterion variable was the score on the Beck Depression Inventory. The model eliminated having children, educational level, household income, sexual orientation, and being in a committed relationship, leaving perceived support, and being in psychiatric or psychological treatment as significant contributors. Even when all significant factors were taken into consideration, SSS scores still accounted for 15% of the variance in BDI scores.

Research question 8: Is stage of coming out as measured by the Stage Allocation Measure related to self-silencing and/or depression in lesbians? Two 3-level, one-way ANOVAs were performed with lesbians' SSS, BDI, and SAM scores.

Frequency of each response (1-6) on the SAM is reported in Table 18. Stage on the SAM (independent variable) was significantly related to both SSS scores (F (2,71) = 8.684, p<.001) and BDI scores (F (2,71) = 7.210, p= .001). ANOVAs are reported in

Table 17

Summary of Participants' Multiple Regression Analyses for Demographic Variables and SSS Scores (Predictor Variables) on BDI Scores (Dependent or Criterion Variable)

	Multiple Regression Analysis				
Dependent Variable					
And Predictor Variable[a]	F	df	Cum R^2	B at step	*B* at step
BDI	12.827	1,139			
Step 1 Perceived Support			.110	-0.344	-.340
Step 2 Treatment			.168	3.353	.247
Step 3 SSS Score			.316	0.135	.430

a – Variables were retained and a new variable was brought in at each step.

Table 18

Frequency of Stages on Stage Allocation Measure (n=85)

Stage	Frequency
Not completed	2
1	1
2	0
3	1
4	14
5	8
6	59

Table 19. Post hoc analyses indicated that all three groups were different from each other on both measures. For both dependent variables, means were highest (indicated most self-silencing and most depression) among those at stage 5. The next highest group were those at stage four. Participants in stage 6 had the lowest depression and self-silencing scores.

Summary of results

The purpose of this study was to determine whether self-silencing, one of the predictors of depression in heterosexual women also predicted depression in lesbians. One hundred and seventy volunteers filled out questionnaires regarding depression, self-silencing, and stage of coming out (lesbians only). Measures included a demographic questionnaire, the Beck Depression Inventory (BDI), the Silencing the Self Scale (SSS), and the Stage Allocation Measure (SAM). Demographic questions indicated that the age of participants did not differ by sexual orientation. In addition, members of both groups were equally likely to be in a committed relationship, and educational achievement of subjects and their spouses were similar between groups. However, lesbians were less likely to be married, have children, and their relationships were significantly shorter in duration than heterosexual women. In addition, lesbians were less likely to practice a religion, less likely to be a member of a minority group, and had higher household incomes than their heterosexual counterparts. Lesbians were more likely to be in counseling or psychotherapy, but both groups were equally likely to be in treatment for a psychological or psychiatric problem. Lesbians felt they had more support from spouses and friends, but heterosexual women perceived more support from religious

Table 19

Analyses of variance for stage of coming out (SAM score) and score on SSS and BDI

	Stage 4		Stage 5		Stage 6			
	X	*SD*	X	*SD*	X	*SD*	df	F
SSS	92.04	22.14	95.04	17.09	71.79	19.80	2, 71	8.684**
BDI	11.54	7.15	14.63	9.13	6.26	0.84	2, 71	7.210**

**p<.01

communities. Lesbians scored higher (indicating more self-silencing) on the total measure as well as on every subscale of the Silencing the Self Scale. Only the total measure and one of the subscales, the Silencing the Self subscale, were significantly different between the groups. There was no difference between lesbians and heterosexual women on the BDI.

A factor analysis of the SSS yielded mixed data. There were 7 factors to Jack's 4; there was some similarities between the scales that emerged and Jack's scales. The investigator believed that participants answered at one end of the scale and that they were confused by the fact that the response scale was not repeated on each page of the measure, and by response set. Thus, appropriate care should be taken in interpreting results.

Correlations between demographic factors and scores on the SSS and the BDI demonstrated that the two measures are highly intercorrelated, paralleling Jack's initial findings. Those in a committed relationship and those who were married had lower scores on SSS. Being in a committed relationship was related to lower BDI scores as well. Being in treatment for psychological or psychiatric problems was directly related to higher scores on SSS and BDI. In addition, the relationships between certain variables differed between sexual orientation groups. Having children, income, education, and perceived community support all related differently to the SSS between groups. Perceived helpfulness of spouse correlated differently between groups in the BDI scores.

A hierarchical regression analysis yielded two demographic factors that contributed to the variance in BDI scores. Variables included perceived support and being in treatment for psychological or psychiatric problems. SSS scores still accounted for 15% of the variance in BDI scores after the above variables were added in. Finally, an ANOVA demonstrated that stage of coming out contributed significantly to lesbians'

scores on the SSS and the BDI. It was found that the most depressed and self-silenced were those who endorsed stage 5, followed by those at stage 4. The least depressed and self-silenced were those at stage 6.

Chapter 5

Discussion

The primary purpose of this investigation was to explore the relationships between depression, self-silencing, and sexual orientation. More specifically, the study was intended to measure depression and self-silencing in lesbian and heterosexual women, and to compare those two groups. The inquiry was intended to address the substantial gap in the literature about lesbians and depression. It also was intended to build on the understanding of the construct of self-silencing and its relationship to depression.

Instruments for this investigation were selected to measure the phenomena of depression and self-silencing, as well as to collect salient data about participants. Instruments selected included the Beck Depression Inventory, the Silencing the Self Scale (with four subscales), a demographic questionnaire, and for lesbians, the Cass Stage Allocation Measure. The demographic questionnaire was designed to collect information about factors that have been shown in the past to impact depression.

It was hypothesized in Chapter 2 that lesbians would be less depressed than their heterosexual counterparts. However, no significant difference was found in depression between lesbians and heterosexual women. In fact, the data indicated that lesbians had higher scores on the BDI, though the differences did not reach significance. It was also hypothesized that lesbians would be less self-silenced than heterosexual women. This hypothesis was also not supported.

A discussion of the results and explorations of possible reasons for the findings, as well as discussions of relevant literature follows below. The implications of this study will be examined. In addition, areas for further research will be suggested.

Research Question 1

A) What are the demographic characteristics of the subjects by total group and by sexual orientation (lesbian and heterosexual women)?

The aim of this investigation was to identify two groups that differed only in sexual orientation, and were as closely matched as possible on other demographic factors. Age was an important part of the design of this study because of the relatively late age of coming out for lesbians (around 25 years). This sample achieved an appropriate age range with means in mid- to late-thirties. Other investigations consistently have shown lesbians with higher educational levels and incomes than their heterosexual counterparts. (Rothblum 1990; Rothblum & Factor, 2001) In the present investigation heterosexual women had higher educational levels, and that is thought to be because one significant recruitment source was graduate students in the College of Human Resources and Education at West Virginia University, a group which was overwhelmingly heterosexual.

The finding from other investigations that lesbians generally have a higher income was upheld in the current study (Rothblum, 1990; Rothblum & Factor, 2001.) In addition, their decreased likelihood of being married and having children was replicated here. It is possible that the reason for increased numbers of married lesbian respondents was that in this investigation, participants were asked whether they were married, and told, "This does not have to be a legal marriage". This was not the case in other investigations. Far more lesbians responded that they were married in this investigation than in other investigations. (For example, 1.6% of the Rothblum, et al. 2001, lesbian sample responded that they were married, while 22% of the current sample reported being married. Not much time has elapsed between the two investigations.) These different approaches probably suggest two different issues: one approach identifies

lesbians who are in heterosexual marriages, and the other addresses how many lesbians have decided that their relationship is enough like a legal marriage that they want to be seen as married. At the same time, it should be noted that many lesbians who are in long-term, committed relationships do not want to be seen as married and therefore would not characterize themselves as such. This is taken from a recent letter to the editor of Options: Rhode Island's Lesbian and Gay Newsmagazine:

> Recent letters in Options speak out against gay "marriage" and in support of civil unions for what I believe are the right reasons . . . the institution of marriage discriminates against lesbians, gay men, and anyone "single" for not being a traditional family, entitled to receive tax benefits, club membership benefits . . . as feminists, we could not live choosing to be part of what we believed to be a misogynist system of court sanctioned woman-hate. (Glass, 2002)

As far as can be discerned, there is no psychological research on the phenomenon of "lesbian marriage" but it is clear that there is significant controversy about it extant in current lesbian social dialogue. However, 2/3 of the lesbians in this investigation who identified themselves as in a committed relationship indicated that they were married.

Jones and Gabriel (1999) say that lesbians and gay men are "the most active and satisfied – but least acknowledged – consumers of psychotherapy." Liddle (1997) found that lesbian and gay subjects saw more therapists and for longer durations than heterosexual controls. Morgan (1992) reports that lesbians had a significantly more positive attitude toward seeking psychotherapy than did heterosexual women, regardless of whether they had experience in therapy. Rothblum and Factor (2001) found that lesbians were more likely to have been in psychotherapy than their heterosexual sisters. The finding of this investigation that lesbians were significantly more likely to be in psychotherapy is not surprising in this light, even though there was no signficant difference in levels of depression between groups. That the two groups were equally likely taking psychiatric medication or treating themselves with nontraditional methods

for depression, anxiety, or other disorders is also not surprising, given the lack of difference in levels of depression.

While heterosexual women were significantly more likely to practice a religion than lesbians in this investigation, surprisingly the majority of lesbians (52%) practiced a religion. Other inquiries have found lesbians unlikely to be practicing a religion. Rothblum and Factor (2001) found that only 28% of their lesbian sample practiced a formal religion. Clark, Brown, and Hochstein report of gay men and lesbians, ". . . many . . . are quite hostile toward a Western religious heritage whose official doctrine and tradition are homophobic and "heterosexist.""(1989).

While heterosexual women were more likely to have children, lesbians were nearly half as likely to have children as heterosexual women. This is also a more frequent occurrence than in other investigations. While 20% of lesbians in this sample reported they "have children", only 7.9% of Rothblum's sample said they "live with children."

Kurdek (1987) found that heterosexual women rated family and friends as equal in terms of the amount of support derived from them. Lesbians, in contrast, were three times more likely to use friends as support instead of family. In the current investigation, there was no difference between lesbians and heterosexual women in perceived family support. However, lesbians indicated they perceived significantly more support from friends and spouses, which supports previous findings (e.g., Kurdek, 1987; Rothblum,1990; Oetjen and Rothblum, 2000; Rothblum and Factor, 2001). As far as can be determined, there is no previous work directly comparing lesbians and heterosexual women on their experiences with their religious community.

B) How representative is the sample compared to census data? Rothblum and Factor (2001) pointed out that while samples of lesbians often do not reflect diversity of

the general population, it is likely that in fact a random sample of lesbians would not reflect this diversity. In their study they investigated some 300 lesbians and used the lesbians' sisters as their controls. They found that in this group lesbians had higher education and income than their sisters, and in many other ways were a more homogeneous group than their sisters. About nine percent of their sample was comprised of racial and ethnic minority lesbians. Oetjen and Rothblum (2000) had a similar minority participation rate in their investigation of lesbians and depression. This rate of ethic and racial diversity is remarkably similar to that of this investigation: however, it would be dangerous to conclude that only 9% of lesbians are racial and ethnic minorities, and Rothblum and Factor did not conclude this. In fact, much more research is needed to determine whether lesbians are less likely to be racial or ethnic minorities, or whether they are being underrepresented in research as has so often been the case in the past.

Question 2. What degree of self-silencing as measured by the Silencing the Self Scale (SSS) is reported for the total sample and for lesbians and heterosexual women and do the groups differ on this measure?

The finding that lesbians were significantly more self-silenced than heterosexual women in this sample is an unexpected one. Other investigations that point to lesbians enjoying "better general adjustment" than their heterosexual counterparts leads one to expect otherwise (Rothblum, 1990; Rothblum & Factor, 2001). In addition, it is to be expected that living in a way that is visibly outside the cultural mainstream would contribute to one's ability to say what one thinks and feels. Finally, the possibility exists that although there was a statistically significant difference, clinically this is not particularly meaningful.

It should be noted that lesbians' scores were signficantly different from heterosexual women's on the overall measure, as well as the Silencing the Self subscale. It should also be noted that both groups had means that were comparable with Jack's non-depressed undergraduate sample, as well as Berman's undergraduate sample. Scores on the other three subscales, the Divided Self, Care as Self-Sacrifice, and Externalized Self Perception did not differ. Examples of items from the Divided Self subscale include:

·Often I look happy enough on the outside, but inwardly I feel angry and rebellious.

·I find it is harder to be myself when I am in a close relationship than when I am on my own.

Examples of the Care as Self Sacrifice subscale include:

·Caring means putting the other person's needs in front of my own.

·Considering my needs to be as important as those of the people I love is selfish.

Examples of the Externalized Self Perception subscale:

·I tend to judge myself by how I think other people see me.

·I never seem to measure up to the standards I set for myself.

Finally, examples of the Silencing the Self Scale:

·I don't speak my feelings in an intimate relationship when I know they will cause disagreement.

·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.

In sum, it seems that the extent to which lesbians underrepresent or misrepresent their feelings to their partners is greater than those of heterosexual women, at least in this sample. However, they are no more likely than their heterosexual counterparts to judge

themselves by others' standards, to subvert their needs in service to their partners', or to hide or split off part of themselves to keep peace.

Many investigators have commented on the apparent closeness of lesbian relationships. The majority of lesbian subjects in an investigation by Peplau, Cochran, Rook, and Padesky (1978) described their relationships as "extremely close." Kaufman, Harrison and Hyde (1984) propose a model of treatment for lesbian couples who are "closely merged" and "troubled." Burch (1982) suggests that "women have a greater pull toward merging and loss of boundaries and that in lesbian relationships this pull is very strong." Kirkpatrick (1991) discusses the "tendency (in lesbians) toward fusion or merger, in which the desire for togetherness dominates the couple's life and precludes individuality." She then suggests that this merger creates difficulties when painful issues must be discussed, and proposes that lesbians may fail to have important discussions in service to harmony in the relationship.

If it is true, as the literature suggests, that lesbian relationships are characterized by merger or fusion in a way that heterosexual relationships are not, it may explain the finding that lesbians are more self-silenced than heterosexual women. This is a particularly useful explanation in light of the fact that lesbians scores were only different on the Silencing the Self subscale. It seems that the "closeness" of these relationships may make it challenging for couples to disagree, leading to partners' constriction in saying what they think.

Question 3. What degree of depression as measured by the Beck Depression Inventory (BDI) is reported for the total sample, and for lesbians and heterosexual women and do the groups differ on this measure?

This is the first known investigation that has directly compared heterosexual women's and lesbians' BDI scores. Rothblum and Factor (2001) compared lesbians' scores on the Brief Symptom Inventory with their heterosexual sisters, and found that on the depression scale, there were no differences between the groups. Oetjen and Rothblum (2000) administered the Center for Epidemiological Studies Depression Scale to lesbians and found that the mean score was 14.49, below the cutoff score for clinical level of depression at 16. There was no reference group in this investigation. Both of these findings were supported by this inquiry.

Lesbians have some risk factors for depression that are less prevalent for heterosexual women. For example, lesbians have higher rates of alcoholism, more history of suicidal behavior, and are less likely to be married than heterosexual women (Rothblum, 1990). However, heterosexual women are at risk for depression in ways that lesbians are not. For instance, they are less likely to be employed outside the home for pay, more likely to be solely responsible for child care, and may have lower overall self-esteem (Rothblum, 1990; Oetjen & Rothblum, 2000; Rothblum and Factor, 2001). One wonders if it is not stressful situations such as those enumerated above that increases women's risk for depression rather than stressors that are unique to women.

Question 4. What factors emerge from an analysis of the SSS items and how do they compare with Jack's seminal work?

The seven factor solution suggested by the factor analysis confirmed some of Jack's scales, but others failed to hold. The most intact scale was the Silencing the Self subscale; another factor collapsed the Divided Self and Externalized Self-Perception subscales. Jack and Dill (1992) warned that the Care as Self-Sacrifice subscale was

"marginal" because of it's relatively low alpha levels. This scale was not reproduced in this investigation.

Since the researcher noticed the problems with response set, another, exploratory factor analysis was conducted without the reverse-scored items. The solution is presented in Appendix J.The factor analysis conducted yielded very similar results to Jack's analysis of her items, as well as another analysis conducted by Stevens and Galvin (1995). They found that while for the most part the factors were similar, five items were problematic. Two of the five were reverse-scored items (items 1 and 11.) It would be helpful to see the design of their questionnaire and to know whether their respondents were answering consistently with other items. It seems that having just a few reverse scored items could be very confusing – it might be better to have either more such items or none. Stevens and Galvin did not have problems with item 12 or item 22. However, in both the present investigation and in Stevens' and Galvin's, item 16 loaded on Externalized Self-Perception rather than on Divided Self, as Jack construed it. In addition, in both investigations, item 20 loaded on Care as Self-Sacrifice rather than Silencing the Self. Given that these findings show some consistency, it seems that at least some items or scales of the SSS need to be reworked. This is especially true in light of the fact that lesbians' scores on the SSS in general, and the Silencing the Self subscale, were significantly higher than heterosexual women's scores. It is crucial to have the construct validity of the measure clear before making assertions about theories and constructs upon which the research rests.

Question 5. What is the relationship between the demographic variables of the subjects and scores on the SSS and the BDI?

It bears repeating that the significant correlations found in this investigation are modest. However, it is hardly suprising that participants who score higher on the Beck Depression Inventory were more likely to be in some kind of psychiatric or psychological treatment. There is a lack of relevant literature regarding the likelihood of people with depression seeking out treatment though many investigators agree that there is much undiagnosed and untreated depression in the community (e.g., Greenberg, Stiglin, Finkelstein, & Berndt, 1993; Coryell, Endicott, Winokur, & Akiskal, 1995; Bland, 1997; Schonfeld, Verboncoeur, Fifer, Lipschutz, Lubeck, & Buesching, 1997; Greden, 2001). Given the intercorrelations between the two measures, it is also not surprising that subjects scoring higher on the SSS were more likely to be in treatment. The inverse relationship between being in a committed relationship and being in treatment has not been directly examined either, but several studies have found reduction in depressive symptoms and psychological distress among married women, a finding that was replicated in this investigation (Pearlin & Johnson, 1977; Ross, 1995; Hope, Rodgers, and Power, 1999.) At least one study found that the benefits that married women enjoy in terms of reduced depression extends to women who are cohabiting, as would be the case with many lesbian women (Ross, 1995.)

It is less easy to explain the inverse relationships between SSS scores and probability of being married or in a committed relationship. It is true that both this inquiry as well as Jack's (1991) original work found that BDI scores and SSS scores are highly intercorrelated. However, it would seem probable that those who are able to, or feel compelled to, represent their experience clearly to their partners would experience more conflict in a relationship and would therefore be less likely to be in a relationship. One explanation is that low SSS scores (or less self-silencing) may be related to having

strong relationship skills, and that these skills translate into a higher probability of being in a committed relationship or a marriage.

Question 6. Do differences exist between groups in any of the relationships between demographic factors and depression and/or self-silencing?

When age was correlated with SSS scores above (Question 5) it was found that the two were orthogonal. Strikingly, however, when the correlations were broken down by sexual orienation group, it emerged that age protects lesbian women from self-silencing, while putting heterosexual women at risk for it. Popular culture gives us numerous examples, especially in books and movies, of women who find their voice as they get older (i.e., "Shirley Valentine," "Steel Magnolias," and "Beaches" which was both a movie and a book by Iris Rainer Dart, 1985.) Incidentally, these were all about heterosexual women. While no empirical research could be found on this topic, there has been some theoretical discourse. Gail Sheehy, in her 1995 book, New Passages, writes about being in one's thirties.

> Today the transition to the Turbulent Thirties marks the initiation to First Adulthood. Everyone *wants to be something more* (italics hers). It is natural to become preoccupied at this stage with crafting a "false self," . . . There is nothing wrong with projecting this false self to the outside world . . . so long as it isn't too distant or disconnected from who we really are (pp. 52-53).

However, women repeatedly state, in Gilligan's In a Different Voice (1982), as well as in Belenky's, et. al., Women's Ways of Knowing (1985), as well as in Jack's Silencing the Self (1991), that this "false self" *is* too distant or disconnected from "who we really are." Sheehy continues:

> Over and over again, with conviction, women who have actually crossed into their fifties tell me, "I would *not* go back to being young again." (Italics hers.) They remember all too vividly what it was like to wake up not knowing exactly who they were, to be torn between demands of

> family and commands of too many roles, and often losing focus in the blur of it all (p. 151).

It seems that while this resurgence of voice among women at midlife has gotten some attention, many women, especially older women, are still struggling to be heard. In addition, the younger women in this investigation have been raised in a world in which there was at least a relatively visible subculture in which girls' and women's voices were important, even if this was not so in their own families. This was largely not the case for women currently at midlife.

By contrast, lesbians who are at midlife now are of the Stonewall generation. While some lesbians were rioting in the streets of New York in 1968, most were hiding the best they could in their everyday lives. These women lived in physical danger if they were too "out." It is a small wonder that the slogan for this generation became "Silence = Death." After the oppressive silence around homosexuality that existed before the late 1960's in this country and most others, it became clear that silence was the enemy. What followed Stonewall was an increase in visibility among homosexuals that was unprecedented, and continues to increase even now.

Intestingly, however, younger lesbians (who in this investigation are, relative to their elder lesbian counterparts, more self-silenced) are taking on such tasks as buying houses and having babies in their lesbian relationships. It will be interesting, over time, to see what happens to lesbians who play the roles that seem to have forced so many heterosexual women into silence for so long. Having so many choices around their fertility as well as relatively more help from their partners (Rothblum, 1990) will likely mitigate the pervasive self-silencing that has overwhelmed heterosexual women for so long.

Having higher household incomes, educational levels, children, and more perceived community support are significantly more protective against self-silencing for lesbians than for heterosexual women. The literature provides no insight into the reasons for these findings. It should be remembered that household income is just that – it does not represent the amount the participant earns but the amount that she and her partner earn. Lesbians are nearly all employed for pay (Rothblum, 1990) and it is therefore likely that a high household income is tied to a high individual income for that participant. It is less likely among heterosexual women, who are more likely to be working inside the home raising children (Rothblum, 1990). So it may be that working for pay and having better employment is related to decreased self-silencing.

Age protects heterosexual women from self-silencing, while it puts lesbians at risk for it. Again, a lack of relevant literature leaves room only to hypothesize about the causes of this differential protection/risk phenomenon.

Protection against self-silencing provided by higher educational levels is more difficult to explain. As lesbians start to come out in college, the experience may be one of consciousness-raising, being involved with gay and lesbian groups, and meeting activists in college communities. However, heterosexual women's interests may be more diverse. These women may be interested in having their consciousness raised, but they may well not be as passionate about it as women whose identity is potentially so profoundly impacted by being a member of a sexual minority group.

Regarding having children, Oetjen and Rothblum (2000) state, "At this point no study has examined the possiblity that childrearing might predict depression among lesbians, but related research suggests that this might be true." This investigation found that there was no difference between lesbians and heterosexual women in the degree to which having children correlates with depression. This indicates that having children

would be related to having depression, as it has been shown to be a risk factor for depression in heterosexual women (Rothblum, 1990; Mirowsky, 1996; Sprock & Yoder, 1997).

However, having children correlated inversely with SSS scores among lesbians. There are many possible explanations for this finding. For one thing, SSS scores were lower, indicating less self-silencing, among lesbians with higher education and income levels. (It is important to note that education and income are highly intercorrelated among both groups as well.) Having children was also significantly correlated with household income. The fact is that for two women in a monogamous relationship, having children is very expensive. Both artificial insemination and adoption are very expensive, often costing thousands of dollars. So it could be that the low SSS scores are an artifact of socio-economic status and not directly related at all to having children.

It is also possible, however, that bringing children into a committed lesbian relationship requires women to be less self-silenced. It is much easier to hide being in a romantic relationship than it is to hide the fact that one's child sees both women as mothers. One has to be comfortable to be known in the schools, at work, in the community, by neighbors as one of two women parents of the child.

In addition, there is also a fair amount of evidence that lesbians share childrearing responsibilities more equitably than heterosexual couples (Rothblum, 1990; Chan, Brooks, Raboy, & Patterson 1998; Oetjen & Rothblum 2000; Rothblum & Factor, 2001.) It is not surprising that it would require skillful maneuvering of each member of the couple's needs and wishes to divide childcare equitably, and so it makes sense that lesbian couples who are raising children are less self-silenced than their childless lesbian counterparts.

The increased protection afforded lesbians by increased perception of social support can be understood in two ways. First, when socializing, one runs the risk of exposing one's sexual orientation by being with others whose sexual orientation is known. Second, it is likely that in the course of socializing, one will identify more powerfully with the group and will therefore gain more awareness of the minority group and its struggle.

Question 7. Are there differences between groups or on any demographic variables in the degree to which self-silencing predicts depression?

As discussed above, being in a committed relationship can be an important protective factor against depression. This has been widely suggested about people in general, but it has also been discussed specifically about women (see question 5 discussion), and also about lesbians. Leavy and Adams (1986) found significant positive correlations between being in a lesbian relationship and self-esteem, self-acceptance, and social support. Bell and Weinberg (1978) found that lesbians who were in "marital" relationships experienced less depression than other lesbians. Oetjen and Rothblum (2000) found that being in a lesbian relationship was associated with decreased depression.

Numerous studies connect the inverse relationship between perception of social support and depression in the general population as well as in women (e.g., Rodriguez-Vega, Canas, Bayon, & Franco, 1996; Hays, Krishnan, George, Pieper, Flint, & Blazer, 1997; Lee, 1997; VanderZee, Buunk, & Sanderman, 1997.) Among lesbians, Ayala and Coleman (2000) found negative relationships between depression and social support from family and social support from friends. Kurdek and Schmitt (1987) determined that lesbians who perceived more social support indicated less psychological distress.

Rothblum (1990) reports that lesbians are likely to name friends, pets, therapists, 12-step organizations as sources of support while heterosexual women most commonly name family and friends. The findings of this investigation lend support to previous findings that women in general and lesbians in particular experience less depression when they perceive sufficient social support.

The relationship between being in psychiatric treatment and BDI scores is discussed at length above (see question 5). It is to be expected that since being in treatment for psychological or psychiatric problems was a significant predictor of BDI scores that it would be found here to be a signficant contributor to the regression equation. No similar regression studies were found in the literature.

The role of sexual orientation in depression is one of the areas for exploration in this study and is one of the major hypotheses of the investigation. This regression model indicated that once other variables (committed relationship status, social support, and being in treatment for psychological or psychiatric problems) are accounted for, that sexual orientation contributed significantly to the variance in depression scores. However, it accounted for less than 1% of the variance. It is difficult to attach meaning to this finding given the small amount of variance accounted for, and that so many lesbians were in psychotherapy when compared with their heterosexual counterparts. It would be helpful to examine the relationship between depression and other forms of psychopathology in lesbians and their relationships to seeking psychotherapy to better understand this. However, since Rothblum (1990) reports that lesbians enjoy better general adjustment as well as higher self-esteem than their heterosexual counterparts, it doesn't seem likely that lesbians are more likely to suffer from psychopathology.

Rothblum and Factor (2001) provide the only direct evidence about the relative frequencies of depression in lesbian and heterosexual women. They found that lesbians

had similar depression scores to their heterosexual sisters. However, the findings also contradict previous theory that lesbians would be less depressed than heterosexual women (Rothblum, 1990). Both groups in the current investigation were generally nondepressed, had fairly high socioeconomic status, and were well educated. It is possible that in her theory paper, Rothblum underestimated other sources of stress in lesbians' lives, and overestimated the protection they enjoy from factors such as being predominantly responsible for childcare and not being employed outside the home. The other possibility is that the heterosexual group in the current study was somehow protected from depression. As the two major recruitment sources were churches and WVU, this is possible, because both education and practicing a religion protect against depression (e.g., Bromberger & Matthews, 1996; Maltby, Lewis, & Day, 1999; Murphy, Ciarrochi, Piedmont, Cheston, Peyrot, & Fitchett, 2000; Schnittker, 2001; Strawbridge, Shema, Cohen, & Kaplan, 2001.)

It was the intention, in this investigation, to make the samples as alike as possible. Rothblum and Factor (2001) did this by using sisters as a comparison group, which is very helpful in terms of controlling for biological loading for depression. However, the sisters were different in many ways; they differed in education, weight, and practicing religion. Perhaps most compellingly, they differed significantly in geography – lesbians were significantly more likely to live in urban areas. For the most part, in this investigation, participants all lived in urban areas (with the exception of WVU graduate students.) Nevertheless, Rothblum's and Factor's findings were replicated here.

This investigation has shown that once other major demographic variables are entered into a regression equation, the Silencing the Self Scale still accounts for a significant amount of variance in BDI scores. In Jack's original work on the Silencing the Self construct and scale she found that the SSS was intercorrelated with, but different

from, scores on the Beck Depression Inventory (1992). Carr, Gilroy, & Sherman (1996) had similar findings but only for white women. Other studies have found this significant relationship between SSS scores and BDI scores among women, but not among men (Thompson, 1995; Page, Stevens, and Galvin, 1996; Koropsak-Berman, 1997). One study found that SSS scores predicted BDI scores for both women and men (Duarte & Thompson, 1999). Gratch, Bassett, and Attra (1995) found that SSS scores were related to BDI scores across genders and ethnic groups. Participants included Asian, African American, Caucasian, and Hispanic undergraduates.

Question 8. Is stage of coming out as measured by the Stage Allocation Measure related to self-silencing and/or depression in lesbians?

Several investigators have suggested that there is a relationship between depression or other psychiatric symptoms and "outness." Kahn states:

> The ability to be open about one's lesbian identity is associated with integration of personality, psychological health, and authenticity in interpersonal relationships. (1991, p 47)

Morris, Waldo, and Rothblum (2001) tested a structural equation model that predicted, in part, that "outness" would be inversely related to psychological distress. This was confirmed. This model maintained across ethnic lines for all groups (African American, Latina, Asian, Native American and Caucasian) except Jewish women. Finally, Jordan and Deluty found that "the more widely a woman disclosed her sexual orientation the less anxiety, more positive affectivity, and greater self-esteem she reported"(1998).

These findings and assertions were partially borne out by this investigation. While being at Stage 6 was associated with lower scores on the SSS and the BDI, Stage 5 was associated with much higher scores on the two measures, and scores on the two measures

associated with Stage 4 fell in between Stages 5 and 6. In fact, mean scores at Stages 4 and 5 on the BDI indicated clinical, albeit mild, depression.

In her discussion of Stage 4, Cass states:

> A philosophy of fitting into society, while also retaining a homosexual lifestyle, is adopted and entails the continued maintenance of a passing strategy (pretending heterosexuality) at pertinent times. This strategy effectively prevents one from being faced with the reactions of others towards one's homosexuality.

Stage 5 is characterized by:

> . . . fierce loyalty to homosexuals as a group . . . Anger about society's stigmatization of homosexuals leads to disclosure and purposeful confrontation with nonhomosexuals . . . When (reactions are not) negative, this is inconsistent with expectations, and dissonance is created. Attempts to resolve this dissonance lead to movement into the final stage (Stage 6, Identity Synthesis.)

It is clear from Cass's description that Stage 5 is fraught with anger and confrontation, and so it is not surprising that lesbians in this stage experienced more depression than those in Stage 4, a more passive stage that is relatively tranquil. It is less easy to understand why women at Stage 5 are more self-silenced than those at Stage 4, as the latter stage is clearly characterized by self-silencing behavior. One explanation is that lesbians at Stage 5 are very rule-bound and thinking in very black-and-white terms, and therefore supress any parts of themselves that don't fit into their notions of rightness.

It should be noted that there has been some criticism of Cass' Stage Allocation Measure as a measure of outness. Degges-White, Rice, and Myers (2000) interviewed 12 lesbians and found that the stages were not good matches for the experiences of the women. Kahn (1991) argued that while respondents may identify with Cass's descriptions, their behavior does not necessarily correspond to the stage they endorse. However, more research is clearly needed to elucidate this finding, and its relationship to other researchers' findings.

Limitations of the study

There are several factors that limit the generalizability of the results of this study. As mentioned, minority women were not represented in this investigation in the same proportions that they exist in the population. Second, there were methodological problems with the BDI and the SSS. Third, this investigation fell short of its target of one hundred subjects in each group. This may have restricted the power of the statistical measures. However, there were only a few findings that were directional but not significant that were relevant to the main research questions and hypotheses.

There were several problems that arose during the data collection portion of this investigation. There was difficulty with recruiting similar samples. The largest portion of the data from heterosexual women came from churches, WVU graduate students, and a group of social workers. The largest portion of lesbians came from churches, Providence Pride, and a women's outdoor group in Pittsburgh. Great efforts were made to find a group of lesbian graduate students, as well as an outdoor group that was not for lesbians, but none were found that were willing to participate in this investigation. It is thought that Pride is a wide swath of lesbians. There is no admission fee and the event is centrally located. It only takes place once a year, and there is a lot of advertising about the event. Although the group from Pride is a convenience sample and should not be construed to be random, it may be that such a group is as close as is possible to come to random, without geographical diversity (Rothblum and Factor, 2001).

While collecting data, it was found that a small number of women failed to complete the entire BDI. This problem was noticed early, and afterward participants' attention was called to the fact that there was a reverse side to the measure. Most people did complete the whole measure, but 11 subjects omitted items 14-21. This happened both in groups (in spite of the attention called to the measure) and at Pride, where

participants were given packets a few at a time, as they walked by our table. The investigator attempted to alert all participants, but there were some omissions anyway. It was thought that this error might be other than random. As we know, people with depression have problems with memory and attention, so there was concern that omitting these women would result in biasing the sample. However, as there was additional concern about changing the nature of the measure, those participants were omitted.

The SSS had some problems as well. For one thing, the SSS is written as if the respondent is currently in a romantic relationship. When they asked about this, subjects were instructed to think of their last relationship. If they did not want to do that, they were asked to answer hypothetically, as if they were in a relationship. Nevertheless, there were two participants who did not answer any question that was about being in a relationship.

In addition, there was a problem with the design of the questionnaire. Respondents were asked to rate their reactions to statements by circling a number, one through five. One indicated that the respondent strongly disagreed with the assertion, and five, that she strongly agreed. Five items, numbers 1, 8, 11, 15, and 21, were reverse scored. However, the investigator did not write the scale on pages 2, 3, and 4 of the measure. This seemed to cause quite a bit of confusion. The answers given were more consistent with a response set than they were internally consistent. Again, it was thought that participants with depression may have had more difficulty with attention and concentration, so the error might not be random. In addition, it was impossible, on a case by case basis, to determine which responses were in error and which were correct. Finally, the order of measures was not randomized, and there could have been an ordering effect the resulted from the way the measures were presented.

Contributions of the study

This study has found results indicating important issues in the relationship of self-silencing and depression for lesbians and heterosexual women lives. What the current investigation points to is that perhaps silence is a more complex issue for lesbians than the SSS accounts for. Being a lesbian in this culture requires that one constantly strike a balance between "outness" and "closetedness." For example, being out at work is a problem for many women, but it is probably important to one's mental health to be out, at least in some arenas (Morris, Waldo, and Rothblum, 2001). Having children complicates this even further.

To be sure, the research on "fusion" or "merger" cited above indicates that lesbians are at least as driven by interpersonal relationships as heterosexual women are, and perhaps more. Thus it would be a mistake to conclude that connection is less of an issue for lesbians than for heterosexual women. This investigation seems to have tapped into that to a certain extent, finding that lesbians are more self-silenced than heterosexual women, especially when it comes to representing their experiences when they believe it will cause conflict. Further research is needed to better understand lesbians' experiences in relationship, the mechanism behind the self-silencing behavior, and whether it is related to psychopathology in a way that was not detected by this investigation.

In addition to adding to the theoretical base of knowledge in the self-silencing/depression domain, this investigation provided new information about depression in lesbians, as well as self-silencing behavior in lesbians. As this group is routinely understudied (Rothblum, 1990; Oetjen & Rothblum, 2000; Rothblum & Factor, 2001), it is an important piece of recently accumulating literature about this phenomenon. The study confirmed some previous findings, while challenging others.

Surprisingly little is known about everyday lives of lesbians. This study attempted to provide some information about aspects of lesbian life that are rarely explored. For instance, some insight into religious behavior was provided. In addition, this investigation looked at lesbians' perceptions of their relationships, rather than legal or social definitions, by asking them to report they were married if the saw themselves as such. Another area that was examined in this investigation involved lesbians and childrearing. These are all activities that lesbians are doing all the time, but we know so little about the role they play in mental health. And as this inquiry has confirmed, it is dangerous to assume that childrearing or religion or any other demographic variable impacts lesbians' lives in the same way that heterosexual women's lives are impacted.

This investigation also attempted to break some ground in the area of lesbians and self-silencing. No one has published on this topic before, so it was fertile ground for an investigation. There were theoretical reasons to believe that lesbians would be both more and less silenced than heterosexual women, so this exploratory work was essential. It was also important to examine the relationship between self-silencing and depression. The direct relationship that exists for heterosexual women does not hold for every group, and this study suggests that lesbians may be one of the groups that it does not hold for.

There is some work that has been done with lesbians and depression, and this inquiry supported most of the previous findings, including the lack of difference in the prevalence of depression between lesbians and heterosexual women, the importance of social support in protecting lesbians from depression, the role of romantic relationships, the importance of work, and many other demographic factors. It also supported past research the being out in some way protects against depression.

Areas of further research

This domain is in no way thoroughly explored and there is a study to be done at nearly every step along the way. It would be particularly useful to do a similar investigation using a different measure of stage of coming out, to help determine whether it is the nature of coming out or the measure itself, or whether there actually is no relationship between stage of coming out and depression or self-silencing. In addition, it would be useful to collect a sample that contains more minority women, and perhaps a more economically and educationally diverse sample.

An offshoot of this investigation would be to observe what factors are the major contributors to depression in lesbians. Looking in depth into demographic factors, family history, abuse history, and other variables may provide some clues into correlates of depression in lesbians. It might also be useful to use a reference group of heterosexual sisters of lesbians, as did Rothblum and Factor (2001) to look at the biological issues related to depression. Another area of investigation for lesbians and depression might be to examine whether lesbians are more likely to seek help with their depression in relationships with others (i.e., in psychotherapy), and the reasons for the choice to use psychotherapy rather than other methods of treatment.

Finally, it would be valuable to explore self-silencing in lesbians. In particular, it would be useful to have a large sample of lesbians with greater socioeconomic and racial diversity, and look at the role of self-silencing in depression within the group, rather than across groups; this may be more informative, especially in light of the finding here that education and household income are inversely related to self-silencing.

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Appendix A

Script for Recruitment of Subjects

Script for recruitment of participants in groups

"Thank you for taking the time to let me speak to you today. I am conducting a study of lesbians and heterosexual women and the kinds of experiences they have in their relationships, and how these experiences affect their mood. If you participate, you will be asked to fill out 3 or 4 questionnaires. You will be asked some basic information about your life situation, some questions about your mood, and questions about your ideas about how you should be in a relationship. If you are a lesbian or questioning your sexuality, you will be asked to read some descriptions of women and say which is most like you. All of this shouldn't take more than about 45 minutes. Please understand that you are free not to participate if you don't want to. If you have any questions at all, please feel free to ask." I will them tell them where I will be set up for them to pick up packets.

Appendix B

Letter of Information to Participants

West Virginia University
College of Human Resources and Education

Information Form

A Comparison of the Relationship of Self-silencing to Depression in Lesbian and Heterosexual Women

Dear Participant:

Thank you very much for taking the time to participate in this study.

INTRODUCTION

You have been asked to participate in this research study as explained by Samantha A. Kirk. This research is being conducted to fulfill the requirements of a doctoral dissertation in Counseling Psychology at West Virginia University.

PURPOSES OF THE STUDY

The purpose of this study is to describe the similarities and differences of the experience of depression in lesbians and heterosexual women, and to determine whether a current model of depression is descriptive of lesbians' experience.

DESCRIPTION OF PROCEDURES

Your participation in this study will take approximately forty-five minutes. You will be asked to complete three (heterosexual women) or four (lesbians) questionnaires. The first questionnaire will ask for demographic information. The second form will ask about specific symptoms of depression. The third form will ask questions about your ideas about relationships. If you are a lesbian, you will be asked to complete a fourth form which asks you to choose a description that best describes you among five descriptions of lesbians. You will be one of 200 participants. You are free to refuse to answer any question at any time and you may terminate your participation at any time for any reason.

Enclosed are several questionnaires and forms. Please read this document first, carefully, and ask me (Samantha Kirk, the investigator) if there are any questions at any time during participation. If you decide not to participate at this time, please return the materials to me. Otherwise, continue as directed. The questionnaires enclosed should be self-explanatory, but if there are any questions, feel free to ask.

2/28/01

Department of Counseling, Rehabilitation Counseling and Counseling Psychology
304-293-3807
Fax: 304-293-4082
PO Box 6122
Morgantown, WV 26506-6122

WestVirginiaUniversity
College of Human Resources and Education

Page 2 of 3: A Comparison of the Relationship of Self-silencing to Depression in Lesbian and Heterosexual Women

Please fill out the remaining questionnaires in the following order:

-Demographic Data Questionnaire
-Silencing the Self Scale
-Beck Depression Inventory

Finally, you will find Cass' Stage Allocation Measure. PLEASE COMPLETE THIS MEASURE ONLY IF YOU ARE A LESBIAN OR ARE QUESTIONNING YOUR SEXUALITY. Please read each description and place a mark next to the paragraph that best describes you. If you do not identify yourself as a lesbian, simply ignore it. When you complete the measures please place your responses back in the envelope and return them to me.

ALTERNATIVES

You are free to refuse to participate in this study.

CONFIDENTIALITY

Any information about you obtained as a result of your participation in this research will be kept as confidential as legally possible. The only exception to confidentiality is if the investigator is legally required to disclose the information.

RISKS AND DISCOMFORTS

There are no known or expected risks from participating in this study, except for mild discomfort that may result from being asked difficult questions.

BENEFITS

This study is not expected to be of direct benefit to you, but the knowledge gained may be of benefit to others.

2/28/01

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College of Human Resources and Education

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VOLUNTARY PARTICIPATION

Participation in this study is completely voluntary. You may refuse to answer any questions at any time and are free to withdraw from participation in this study at any time. Refusal to participate involves no penalty whatsoever.

CONTACT PERSONS

The following persons are involved with this study. You may contact them at any time if you have additional questions that are not answered here today:

Samantha A. Kirk, M. Ed.	(401) 461-1752	skirk13@home.com
L. Sherilyn Cormier, Ph. D.	(304) 293-3807	

If you have any questions regarding your rights as a human subject you can call the West Virginia University Institutional Review Board/Human Subjects at the following number: (304) 293-7073.

Thank you again for taking time to participate in this investigation.

Sincerely,

Samantha A. Kirk, M. Ed.

2/28/01

Department of Counseling, Rehabilitation Counseling and Counseling Psychology

304-293-3807
Fax: 304-293-4082

PO Box 6122
Morgantown, WV 26506-6122

Appendix C

Demographic Data Form

Demographic Form

In this questionnaire, I am interested in how you define yourself and not how you think others would define you. Please answer accordingly. You are not obligated to answer any questions that you are not comfortable answering. You can leave any item blank that does not apply to you. Please also feel free to provide feedback, written or verbal, about this questionnaire if you wish.

Age (in years at last birthday): _____

Race/Ethnicity: African-American
Asian/Pacific Island
Latina
Native American
White
Other: _____

Sexual Orientation: Lesbian/Gay
Bisexual
Heterosexual

I. Relationship Status

1. Are you currently in a romantic relationship? Y N

A. Are you married? Y N
(This does not have to be a legal marriage.)

B. How long have you been married? _____

C. How long have you been in this relationship? _____

D. Do you consider this a committed relationship? Y N

(For study purposes, I am defining this as a relationship in which both partners have explicitly agreed to remain in the relationship indefinitely.)

II. Children

1. Do you have children? Y N

If yes:
a. How many? _____

b. What are their ages? _____

2. Are you the primary caregiver for your child(ren)? Y N

3. How helpful do you find your spouse/partner to be in raising your child(ren)?

Not at all						Very helpful	
1	2	3	4	5	6	7	N/A

III. Income, Education, and Employment

1. Annual Household Income
(If you and your partner/spouse do not pool income, then consider only your own income)

a. <$15,000 per year
b. $15,000 to $25,000
c. $25,000 to $35,000
d. $35,000 to $45,000
e. $45,000 to $60,000
f. $60,000 to $80,000
g. $80,000 to $100,000
h. >$100,000

2. Education (circle highest level achieved)

a. Some high school
b. High school diploma or equivalency
c. Trade school graduate
d. Some college
e. Associate's Degree
f. Bachelor's Degree
g. Master's Degree
h. Doctoral Degree

3. In what capacity are you employed? _____
(If you work at home as a homemaker or raising children, please indicate that.)

If you are married or co-habitating in a committed relationship:

1. What is your partner/spouse's level of education?

a. Some high school
b. High school diploma or equivalency
c. Trade school graduate
d. Some college
e. Associate's Degree
f. Bachelor's Degree
g. Master's Degree
h. Doctoral Degree

2. In what capacity is your partner/spouse employed (including home and child care)?

_____

IV. Religion

1. Which best describes your religious practice?
   a. Christianity
      i. Roman Catholicism
      ii. Protestantism
         Denomination _____
      iii. Eastern Orthodox
   b. Judaism
   c. Islam
   d. Hinduism
   e. Buddhism
   f. Confucianism
   g. Shintoism
   h. Taoism
   i. Sacred Tribal Beliefs
      i. Native American
      ii. African
      iii. Other
   j. Animism
   k. Polytheism
   l. Atheism
   m. Agnosticism
   n. Other: _____

2. Which best describes the religious practices in which you were raised?
   a. Christianity
      i. Roman Catholicism
      ii. Protestantism
         Denomination _____
      iii. Eastern Orthodox
   b. Judaism
   c. Islam
   d. Hinduism
   e. Buddhism
   f. Confucianism
   g. Shintoism
   h. Taoism
   i. Sacred Tribal Beliefs
      i. Native American
      ii. African

iii. Other_____

j. Animism
k. Polytheism
l. Atheism
m. Agnosticism
n. Other: _____

V. Social Support

Please indicate the degree to which you feel you have the following kinds of support:

1. Family support

None As much as I need

1 2 3 4 5 6 7

2. Support from friends

None As much as I need

1 2 3 4 5 6 7

3. Spousal/Partner support

None As much as I need

1 2 3 4 5 6 7 N/A

4. Support from religious community

None As much as I need

1 2 3 4 5 6 7 N/A

5. Community support

None As much as I need

1 2 3 4 5 6 7

VI. Psychological and psychiatric treatment

1. Are you currently in treatment for, or are you treating yourself for, depression, anxiety, or any other psychological or psychiatric problem? Y N

If yes:
Are you in psychotherapy or counseling? Y N

Are you currently taking any medication prescribed by a physician for depression? Y N

Are you currently taking any medication for anxiety? Y N

Are you taking any medication for any other psychiatric problem, including antipsychotic medications, mood stabilizers, etc.? Y N

Are you treating yourself with any nontraditional methods* for psychological symptoms? Y° N

*Treatments may include St. John's Wort, yoga, massage therapy, meditation, etc.
°Answer "yes" ONLY if you are treating symptoms such as depressed mood, anxiety, tearfulness, chronic tiredness, panic attacks, inability to concentrate, muscle tension, etc., with this activity. DO NOT answer "yes" if you do this for general well being, to reduce stress, or to treat physical disorders.

If you answered yes to any of above questions regarding treatment:
Please describe the kinds of symptoms you are experiencing in the space below.

Appendix D

The Silencing the Self Scale can be found in Jack, D. C. (1991). Silencing the self: women and depression. New York, NY: HarperPerennial. The author can be contacted via email at DanaJack@wwu.edu for permission to use this measure. The measure cannot be reproduced here due to copyright considerations.

Appendix E

The Beck Depression Inventory can be obtained from the Psychological Corporation, 555 Academic Court, San Antonio, TX, 78204. The Psychological Corporation can be reached by telephone at (210) 299-1061 or on the World Wide Web at www.tpcweb.com. The measure cannot be reproduced here due to copyright considerations.

Appendix F

The Stage Allocation Measure can be obtained in Cass, V. (1979). Homosexual identity formation: A theoretical model. Journal of Homosexuality, 4, 219-235. The author can be contacted via mail at 155 South Terrace, Como, Western Australia, 6152. She can be contacted by telephone at (08) 9474 4401 and by email at vcass@perth.dialix.oz.au. The measure cannot be reproduced here due to copyright considerations.

Appendix G

Letters of Permission to use Study Measures

WESTERN
WASHINGTON UNIVERSITY

An equal opportunity university

Fairhaven College

Bellingham, Washington 98225-9118
(206) 650-3680 ☐ Fax (206) 650-3677

Permission for use of the Silencing the Self Scale

You have permission to use the Silencing the Self Scale (STSS) for your research. Please do not remove the copyright information on the bottom of the scale.

Scoring on the STSS is straightforward and instructions are contained in the article in the Psychology of Women Quarterly, Spring, 1992 which you will find included in the package. I want to call your attention to two issues.

- First, you will notice that the last question in the scale can not be analyzed statistically along with the rest of the scale, and is intended for descriptive and explanatory purposes, for example, to determine whether a sample of women may employ standards different from those hypothesized as critical by the scale.

- Second, as indicated in the article on the scale, items #1, 8, 11, 15, and 21 are reverse scored before summing all the items. So, for example, if item #1 is answered with a 2, it becomes a 4 before being added, or a 1 becomes a 5, or vice versa.

- Third, items #1 & #11 have zero to negative item-total correlation in a number of studies. I suggest that you check item-total correlation of these two items for your sample, and leave them out of analysis if they do not approach significant item-total correlation. Be sure to state you have done so, since subscale and total means will look different.

Instructions to respondents are as follows: "Please circle the number which best describes how you feel about each of the statements listed in the scale." Normally, I then ask people to answer regarding their feelings and behavior in relation to an intimate partner. I instruct that if they are not currently in an intimate relationship, to answer according to how they felt and behaved in their last intimate relationship.

The theory behind the scale is described in Dana Crowley Jack, Silencing The Self: Women and Depression. Cambridge, Ma: Harvard University Press, 1991 (paperback, Harper Collins, 1992).

If you have any questions, you are welcome to call me at 206-650-4913. I wish you the best in your work and look forward to hearing about your results. Please see the accompanying form for instructions on updating me with your results.

Thank you

Dana Crowley Jack, Ed.D.
Professor
Email: djack@henson.cc.wwu.edu

THE
PSYCHOLOGICAL
CORPORATION®

The Psychological Corporation
555 Academic Court
San Antonio, Texas 78204-2498
Tel 210-299-1061
Telex 5106015629 TPCSAT
Fax 210-299-2755

December 14, 1999

Ms. Samantha A. Kirk
84 Barlett Avenue
Cranston, RI 02905

Dear Ms. Kirk:

Thank you for your letter concerning your use of the *Beck Depression Inventory®(BDI®)* in your dissertation to explore the relationship of self-silencing and depression in approximately 200 lesbian and heterosexual women.

As a responsible test publisher, we believe it is our duty to protect the security and integrity of our test instruments. Therefore, we cannot allow copies of the test to be included with or stapled in your dissertation. However, two actual test items from the *BDI®* may be included. If you use two items, please be sure the copyright notice appears with the items along with the words "Reproduced by permission of the publisher, The Psychological Corporation."

Also, all testing must be conducted in your presence or that of another qualified individual so that all test materials remain secure

We will gladly grant permission for the use of this test instrument if the above restrictions will be followed. Please indicate your agreement to these terms by signing and returning this letter for our files. When you have returned the signed letter, we will mail you 200 copies of the *BDI®* free of charge. If you need the manual, you may contact Shirley Elizondo in Customer Service at (800) 228-0752, ext. 5427, to order this component. As a student, you are eligible for a 50% discount on the manual; however, you must pay for the order yourself and request the discount at the time you place the order.

Also, please forward a copy of your final dissertation for our library.

Thank you for your interest in our test materials. If you have further questions or needs, please contact us. Good luck with your research.

Sincerely,

Catherine Amaro Baker
Contract Specialist
Legal Affairs

AGREED:

_____

Dr Vivienne Cass
Ph.D., M.Psych., B.Psych., Teach.Cert., Dip.Sch.Mus.
Clinical Psychologist & Psychotherapist
Registered Clinical Psychologist (W.A.)
Member of the Australian Psychological Society

Samantha Kirk
26 Kaufman Rd,
Tiverton, RI
USA 02878

Dear Samantha,

Thank you for your request to use the Stage Allocation Measure. I would be pleased for you to use it in your research and enclose a copy for your use. It is ready to photocopy in two-sided format with stapling on the left - the descriptions of the stages should be opposite each other so that they present together.

Your research topic sounds very interesting. My experience has been that those in the early stages of identity formation who suppress their lesbian sexualromantic attractions can become quite depressed. I would like to receive a copy of your results if possible.

Good luck with it - if there is anything else I can do please let me know.

Yours sincerely,

Vivienne Cass

Appendix H

Institutional Review Board

Letter of Approval

WestVirginiaUniversity
The Institutional Review Board for the Protection of Human Subjects

DATE: February 11, 2000

NOTICE OF APPROVAL FOR PROTOCOL H.S. #14622

This research will be monitored for re-approval annually.
This protocol was first approved on February 11, 2000.

TO: Samantha Kirk and
L. Sherilyn Comier

Project Title: A Comparison of the Relationship of Self-silencing to Depression in Lesbian and Heterosexual Women

SPONSORING AGENCY: N/A

The Institutional Review Board for the Protection of Human Research Subjects (IRB) has approved the project described above. Approval was based on the descriptive material and procedures you submitted for review. Should any changes in your protocol/consent form be necessary, **prior approval must be obtained from the IRB.**

According to the Code of Federal Regulations, Section 312.32, investigators are required to notify the FDA and the study sponsor of any adverse experience associated with the use of an investigational drug that is serious and unexpected. A serious adverse experience is considered any event that is fatal or life-threatening, is permanently disabling, requires inpatient hospitalization, or is a congenital anomaly, cancer, or overdose. An unexpected adverse experience is an event that is not identified in nature, severity, or frequency in the current investigator brochure. Any experience reportable to FDA and the sponsor must also be reported immediately to the IRB.

A consent form*___ is_X_ is not required of each subject.

An assent form___ is_X_ is not required of each subject.

A recruitment ad has___ has not_X_ been approved.

NOTE: Consent form waiver has been approved.

Phone: 304 293-7073
Fax: 304 293-7435
886 Chestnut Ridge Road, Room 202
PO Box 6845
Morgantown, WV 26506-6845

Appendix I

Exploratory factor analysis with reverse-scored items removed

Factor loadings for Silencing the Self Scale items with reverse scored items removed

	1	2	3	4	5
6	**.682**	.203	.001	.181	-.068
7	**.585**	-.057	.226	.392	-.020
16	**.543**	.151	.364	.262	.064
19	**.517**	.288	.164	.390	.041
27	**.795**	.176	-.017	-.093	.273
28	**.696**	.250	.158	.136	.145
31	**.591**	.080	.242	.277	.157
2	-.011	**.610**	.202	.411	.011
13	.414	**.472**	.080	.347	.009
14	.271	**.801**	.212	.056	.095
18	.392	**.466**	.273	.365	.051
23	.274	**.374**	.316	.334	-.051
24	.070	**.735**	.050	.014	.217
26	.234	**.642**	.245	.300	.111
30	.463	**.593**	.349	.152	-.067
3	.067	.086	**.756**	.012	.195
4	.004	.157	**.665**	.373	.223
9	.114	.177	**.711**	-.162	.274
10	.132	.099	**.726**	.005	-.205
20	.307	.283	**.433**	.223	.259
29	.222	.328	**.545**	.099	.128
5	.269	.397	.061	**.533**	-.102
17	.449	.224	.052	**.564**	.158
25	.387	.225	-.137	**.711**	.098
12	.200	.166	.159	-.130	**.704**
22	.069	.053	.253	.395	**.728**

Bolded numbers indicate the highest loading for that item

Samantha A. Kirk

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Cranston, RI 02905
(401) 461-1752
skirk13@cox.net

Education

Ph. D. Counseling Psychology, West Virginia University
Morgantown, WV, 2002
Full accreditation, APA

Dissertation Title: Depression and self-silencing in lesbian and heterosexual women.

Defense: April 22, 2002

Chairperson: L. Sherilyn Cormier, Ph.D.

M. Ed. Counseling Psychology, Rutgers University, 1993
New Brunswick, NJ

B. A. Psychology, Rutgers University, 1990
New Brunswick, NJ

Training

Doctoral Intern Towson University Counseling Center
7/97 – 6/98 Glen Esk
Towson, MD
Full Accreditation, APA

Supervisors Mollie Jaschik-Hermann, Ph.D., Licensed Psychologist
Julie Kobayashi-Woods, Ph.D., Licensed Psychologist

Assumed responsibilities of a staff psychologist for one year. Treated clients in individual psychotherapy, taught a one-semester career exploration course (supervised by Alice Feeney), counseled students specifically for career and drug and alcohol issues. Sat on outreach and intern selection committees. Had two hours individual supervision per week. Provided supervision for doctoral extern, two hours per week. Took special interest and initiative in the delivery of mental health services to gay, lesbian, bisexual, and transgendered students on campus. Assisted in ongoing research project with a faculty member on campus and participated in a research group which focused on various research issues and problems. Conducted two case conferences, participated in weekly two-hour intern seminars to increase knowledge and skills.

Doctoral Practicum **Clinical Neuropsychology**
5/96 – 12/96 Western Psychiatric Institute and Clinic
Pittsburgh, PA

Supervisors: Lisa Morrow, Ph.D., Licensed Psychologist (on site)
Lorrie Rabin, Ph.D., Licensed Psychologist (academic)

Gained experience in neuropsychological testing and in report writing for these assessments. Watched experienced testers give batteries, and practiced giving tests to employees of the clinic. Tests given included the WAIS-R, Wisconsin Card Sorting Test (computerized), Trailmaking Test, Continuous Performance Test, Rey Complex Figure, Finger Tapping Test, Grooved Pegboard, Embedded Figures, Stroop Test, and many others. Testing was done for both clinical and research purposes. Current research at the clinic focuses on diabetics, and on people who have been exposed to organic solvents.

Doctoral Practicum	Carruth Center for Counseling & Psychological Services
8/94 - 5/95	West Virginia University
	Morgantown, WV
Supervisors	Sue Hodgson, Ph.D., Licensed Psychologist (on site)
	I. Claude Southerly, M.A., Licensed Psychologist (on site)
	L. Sherilyn Cormier, Ph.D., Licensed Psychologist (academic)

Provided psychotherapy services for individuals and couples in university counseling center. Clients presented with problems including grief, marital and relationship problems, domestic violence, eating disorders, career development, personal growth, depression, anxiety and included some clients with Axis II pathology. Administered and interpreted career development measures. Received 1 hour staff supervision, 1 hour intern supervision, and 1 1/2 hours group supervision per week on site. Also attended weekly seminars intended to increase knowledge and skill repertoire, as well as bi-weekly staff meetings and monthly case presentations.

Doctoral Practicum	Summit Center for Human Development
9/92 – 6/93	Clarksburg, WV
Supervisors	Jay Fast, Ed.D. (on site)
	L. Sherilyn Cormier, Ph.D., Licensed Psychologist (academic)

Provided psychotherapy services for individuals, including adults and adolescents, and families. Clients presented with issues including grief, adolescent antisocial behavior, domestic violence, panic disorder, obsessive-compulsive disorder, adjustment and personal growth as well as more severe Axis II pathology.

Domestic Violence	The Greenhouse
Counselor Trainee	Meadville, PA
2/91-4/91	

Completed a forty-hour training program that prepared volunteers to work with victims of domestic violence and sexual assault. Topics included being a courtroom and emergency room escort, dealing with police, emergency phone counseling, helping a victim to leave an abusive relationship, and general education and information.

Employment

Crisis Clinician	John C. Corrigan Community Mental Health Center
4/99 – present	Fall River, MA
Clinical Supervisor	James Farrelly, Psy. D., Licensed Psychologist

Conduct clinical interviews with clients who present either voluntarily or involuntarily (under Massachusetts General Law Chapter 123, Section 12). Make assessments regarding dangerousness of clients to self or other, and regarding ability to care for self. Make appropriate recommendation for disposition either independently or in consultation with physician. Provide emergency mental health services to the community either in person or via telephone. As senior clinician, responsibilities include training new staff, consulting with less experienced clinicians regarding dispositions of their clients, managing flow of clients, keeping track of all clients in crisis unit, and reporting to site director each evening on current cases.

Research Assistant John C. Corrigan Community Mental Health Center
7/98 – 1/99 Fall River, MA
Supervisor Debbie Redmond

Conduct research with schizophrenic patients using a variety of protocols. Protocols include clinical trials for neuroleptic medications as well as motor, memory, and language studies. Measures administered include neurocognitive testing, Positive and Negative Symptom Scale, Extrapyramidal Symptom Rating Scale, as well as physiological measures. Additional responsibilities include building databases, subject recruitment, screening, and scheduling. Drug research requires working with complex protocols and screening criteria and maintaining records.

Research Associate Center for Education and Drug Abuse Research
2/96 – 5/97 Western Psychiatric Institute and Clinic
Pittsburgh, PA
Supervisor Peggy Ott, Ph.D., Licensed Psychologist

Administered variety of behavioral, psychosocial, neuropsychological, intelligence, and achievement measures to individuals ranging in age from 6 to 55. Measures used include (but are not limited to) the WISC-III, the WAIS-R, semi-structured clinical interviews for DSM-III-R and DSM-IV, achievement measures, structured psychosocial interviews, and computerized versions of the Wisconsin Card Sorting Test and the Stroop Test (see p. 5 for a more complete list.) Also involved collecting data on observations, administering computer tasks, and writing reports of the semi-structured clinical interviews. Additional responsibilities included recruiting participants for the research project from treatment facilities.

Psychotherapist Chestnut Ridge Counseling Services, Inc.
5/93 – 5/95 Uniontown, PA
Supervisor James Olson, M.Ed.

Saw clients with wide range of presenting problems and levels of functioning for intakes, psychotherapy, and groups. Issues included domestic violence, depression, anxiety, panic disorder, obsessive-compulsive disorder, dysthymia, childhood sexual abuse, sexual assault, schizophrenia, borderline personality disorder, antisocial personality disorder, and dissociative identity disorder. Ran a chronic pain group, and co-facilitated support group
for parents of children with attention deficit hyperactivity disorder. Provided supervision for Master's student.

Teaching Assistant Department of Psychology
9/93 – 5/94 West Virginia University
Morgantown, WV
Supervisor Kevin Larkin, Ph.D.

Taught introductory level psychology for two semesters (with two sections per semester). Classes had approximately thirty students each. Responsible for presenting information, holding office hours, keeping grade book, and reporting grades. In addition administered a quiz each week, graded short papers, assignments from text, and three to four exams per semester. Was required to construct quizzes using questions from a database provided with the text.

	Teaching Assistant	Department of Educational Psychology
	9/92 – 7/93	West Virginia University
		Morgantown, WV
	Supervisor	Ann Nardi, Ph.D.

Taught introductory level educational psychology for two semesters and a summer term (with two sections per semester and one section in the summer). Classes had approximately 30 students each. Responsible for presenting information, keeping grade books, holding office hours, administering and grading tests, homework assignments, and journals, and reporting grades.

Volunteer	**Group Facilitator**	West Virginia University
	Spring Term, 1995	Morgantown, WV
		Human Sexuality Discussion Group

Led discussion group consisting of undergraduate students in a human sexuality course. (Attendance at four groups was mandatory to partially fulfill course requirements.) Group focused generally on human sexuality, but the group generated specific topics for discussion. General goals were awareness of issues involving sexuality and promoting tolerance.

	Peer Counselor	56 Place Peer Counseling and Referral Service \
	Sep 1989-May 1992	Rutgers University
	Supervisor	David Chandler, Ph.D., Licensed Psychologist

Provided one-visit and emergency counseling services to Rutgers University students and New Brunswick community. Was trained in and trained new counselors in a five step intervention model, and supervised shifts. Supervision responsibilities included making necessary referrals, debriefing counselors after difficult contacts, structuring shifts, and utilizing emergency resources in community (i.e. police, ambulance, etc.)

Professional Organization	**Student Affiliate**	American Psychological Association

Presentation

Society for Prevention Research
Problem behavior profiles in preadolescent girls with and without family history of substance abuse
5/8/97

Colloquia

Time Limited Psychotherapy	Panic Disorder
Towson University CC	Tom Filllian, Ph.D.
Towson, MD	Loyola College C. C.
2/98	Baltimore, MD
	2/26/98

Colloquia (con't)

Psychotherapy with Gay and Lesbian Clients
Barbara Slater, Ph.D.
Towson University
Towson, MD
October, 1997

DSM-IV Overview
Western Psychiatric
Institute and Clinic
Pittsburgh, Pa
9/13/96

Effective Group Counseling: Strategies for Training & Practice
Janice L. DeLucia-Waack,Ph.D.
Purdue University
West Lafayette, IN
11/3/95

Introduction to the DSM-IV
Dr. Kevin Peterson
Frostburg State University
Frostburg, MD
10/94

Supervision
Scott Friedman, Psy.D.
Carruth Center for Counseling
and Psychological Services
11/94

Individualizing Sexual
Abuse Survival Treatment
Marolyn Wells, Ph.D.
Georgia State University
Atlanta, GA
4/15/94

Object Relations: Theory & Practice
Marolyn Wells, Ph.D.
Georgia State University
Atlanta, GA
4/27/93

Preparing for Internship
Marolyn Wells, Ph.D.&
Katherine Bruss, Psy.D.
Georgia State University
Atlanta, GA
11/92
3/27/00-3/31/00

Conferences

National Community Crisis Response
National Organization for Victim Assistance

5th Annual Meeting of the Society for Prevention Research
Society for Prevention Research Baltimore, MD
5/6/97-5/8/97

9th Annual CEDAR Conference
Center for Education and
Drug Abuse Research of
Western Psychiatric Institute
and Clinic 4/25/97

Treatment of Anxiety Disorders
Western Psychiatric Institute and Clinic
Pittsburgh, PA
11/8/96

8th Annual CEDAR Conference
Center for Education and
Drug Abuse Research of
Western Psychiatric
Institute and Clinic
Pittsburgh, PA
4/12/96

References

L. Sherilyn Cormier, Ph.D.
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West Virginia University
Box 6122
Morgantown, WV 26505-6122
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James Farrelly, Psy. D.
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Roger Boshes, Ph. D., M. D.
Medical Director
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