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Self-silencing among Punjabi women: the interplay of cultural adaptation, depression, and domestic violence

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Self-Silencing Among Punjabi Women: The Interplay of Cultural Adaptation, Depression, and Domestic Violence

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MASTER'S THESIS

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Madhura Bhadra

June 29, 2012

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Abstract

Silencing the self theory predicts that women in oppressive relationships tend to experience loss of self through self-silencing, and are therefore more prone to depression. Past studies have found that both abuse and immigration are associated with higher levels of self-silencing and depression. The current study investigated the psychometric properties of the Silencing the Self Scale (STSS) and the Beck Depression Inventory II (BDI-II), as well as the validity of the STSS subscales for a specific cultural population. Fifty-five Punjabi women completed the STSS, the BDI-II, and participated in in-depth focus groups for a mixed methods approach to a culturally sensitive exploration of self-silencing and depression. Though Rasch Scale analysis, the study identified the misfit items for both the STSS and BDI-II for this population. Additionally, misfit items and unexpected performance of the scales according to the Rasch Model's expectations are explained by the rich qualitative data to give insight to cultural norms that may cause differential scale performance. The study identified the STSS to be very culturally appropriate for the examination for loss of self for these women, and positively associated STSS scores with higher BDI-II scores as past literature has shown. By adapting a cultural focus, the study also shows how specific Punjabi cultural norms and values in a Western country impact the expression and development of self-silencing and depression. Finally, by illuminating the cultural specificities within these domains, the study sheds light on the culturally specific obstacles that entrap these women in abusive relationships.

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The Interplay of Cultural Adaptation, Depression, and Domestic Violence

In the current era of rapid globalization, immigration is a major issue for both the United States and Canada. South Asian immigrants are the fastest growing immigrant group in Canada, and as of 2006, about 1.5 million India-born immigrants reside in the United States (Canadian Social Trends [CST], 2008; Rytina, 2008). As the demographics become more diverse within Canada and the United States, there is a need for emphasis on culturally sensitive research practices and mental health assessment tools. The continued development of such tools will advance meaningful and productive engagement between service providers and populations of different cultural backgrounds, as well as avoid the potential for misunderstanding, ineffectiveness, and even harm. The South Asian immigrant settlement to Vancouver, British Columbia has made it the second largest immigrant bound city in Canada, with 39.6% of the metropolitan population being of foreign birth (CST, 2008). In cities near Vancouver, Punjabi populations range from 27% to 73% (CST, 2008).

Studies have found immigrants to have higher risks for many physical and mental disorders when compared to non-immigrant populations (Pernice & Brook, 1996). Of these illnesses, unipolar depression is amongst the most common of mental health problems (Nazroo, 1997). Depression is projected to soon become the first leading cause of the global burden of disease in the world, and occurs twice as often in women (Murthy, 2001; Patel, Araya, De Lima, Ludemir, & Todd, 1999). In Canada, specifically, many immigrant populations have been found to have a much higher risk for depression than non-immigrant populations (Miszkurka, Goulet, & Zunzunegui, 2010). Significant variation in the development, expression, and course of this illness across different cultures indicates the need for further research investigating the ways in which immigrant groups experience depression in order to develop appropriate treatments and services (Manson & Kleinman, 1998).

The first step in conducting such research is to define the group with whom the study will engage. Unfortunately, most of the available immigration statistics for Canada repeat a familiar mistake found in much of cultural research. In most studies, Asians are lumped together in a collective category often consisting of those from millions of cities, thousands of states, and across several countries. At best, studies divide this "Asian" group by classifying those from India as East Asian or South Asian, but even this designation is much

too large and often not consistent. In India alone, there are 28 states and seven territories, each with its own culture, traditions, languages, and religions. Immigrant research is littered with inconsistent findings for many theories, potentially a result of many subpopulations being categorized as the same. For example, research on depression for "Asian" populations has yielded an assortment of results with regards to whether or not Asians somaticize symptoms, stigmatize mental health, or seek help for mental health (Bhui, Bhugra, Goldberg, Dunn, & Desai, 2001; Lai & Surood, 2008; Karasz, 2005). Because of the large Punjabi communities that exist nearby Vancouver, Canada, and to avoid the amalgamation of unlike groups, the current study specifically focused on Punjabi women, with the majority of participants being of foreign birth.

The focus of the current study was to assess the relationships between silencing the self, depression, and domestic violence. Silencing the self theory considers interpersonal relationships to be integral to a woman's wellbeing, and identifies inequality and oppression to be destructive to these relationships in a manner that fosters vulnerabilities for depression (Jack 1991; Jack & Dill, 1992). Because of the relational components of the theory, it was thought to be an appropriate framework for depression to use within the traditionally collectivistic Punjabi culture.

History

It is difficult to appreciate the significance and meaning of self-silencing, depression, and domestic violence for Punjabi women in Canada without a basic understanding of the history of this group. It is not the purpose of this study to theorize the direct connections from historical processes and structural forces to self-silencing, depression, and the perpetration of intimate partner violence. However, the experiences and modes of suffering of oppressed women in this group can best be interpreted within this context.

Punjabi immigrants first came to Vancouver, Canada in 1904 (Mayer, 1959). The first thousands of immigrant men were employed in lumberyards, and the Canadian people received this sudden influx of foreigners up until, and throughout, the great depression with resistance (Ames & Inglis, 2010). After the initial wave of immigrants, the Canadian government began to severely restrict Indian immigration as a response to the prejudices expressed, and even proposed the removal of "East Indians" to British Honduras (Ames & Inglis, 2010). The Canadian Immigration Act of 1910 restricted immigration by proclaiming that Indians could only come into Canada if they had continuous passage and 200 dollars, but Punjabi immigrants found a way around

the Act when they chartered a ship to sail directly from India. The result was a bloody conflict in the Vancouver port in which a government official was assassinated. Punjabis still celebrate Mewa Singh, who was responsible for the assassination, and his fighting for equal rights (Chadney, 1989).

Most of the Punjabi population in Vancouver follows Sikhism, and the Sikh temples in Vancouver have traditionally been instrumental in organizing political movements and cultural events. The Khalsa Diwan Society was the first central committee to head many of the temples in Vancouver and in 1967 had the official objective to provide a place where children in the Sikh community could learn their history, language, and culture. Their constitution also stated that it provided a place where Sikh immigrants could accommodate to life in Canada, but not assimilate (Chadney, 1989). This resistance to assimilation is recorded in other studies regarding Punjabi immigration in Canada where there is a balance of tradition and adaptation without assimilation (Bauder, 2006). Relatedly, Ames and Inglis (2010) found in recent ethnographic interviews that a goal of Punjabi immigrants in Vancouver is to "modernize" but never "westernize."

Brah (1996) introduced the idea of transnational diaspora, which proposes that immigrants retain their original culture to create a common identity in the new country. For this reason, it is prudent to consider studies with Punjabi immigrants that have been conducted outside of Vancouver to form common themes and trends. Punjabi immigrants, specifically, have been found to retain religious beliefs and practices, language preferences, cultural traditions, clothing, and even music to form a reoccurring and consistent identity (Helweg, 1999). Even those who oppose the common belief systems associated with Punjabi immigrants are still able to identify what those themes and expectations are (Puar, 1996). Helweg also argues that Punjabis who are originally from rival areas, states or even countries (e.g. Pakistan after the partition), and that are Muslim, Hindu, or Sikh, unite to form a common identity when in a new migrant country (1999). These findings seem to indicate that Punjabi populations in new countries are culturally cohesive and intact. Research findings can therefore be expected to somewhat generalize to most Punjabi immigrant-based communities, irrespective of country, that focus on a common shared identity and culture.

Culture

Culture, when defined as "a shared system of learned norms, beliefs, values, and behaviors that differ across populations defined by region, nationality, ethnicity, or religion" (Hruschka & Hadley, 2008, p. 947),

illustrates the multivariable nature of what culture encapsulates. An immigrant woman has all of these factors highlighted when settling in a new country and culture. It is only through acknowledging the intricate social context that a woman is part of that the expression, understanding, and response to depression can be understood. The cultural fabric in which the lives of Punjabi immigrant women are embedded must be understood not only as having been derived from Punjab, but also as having been transformed by the process of migration. Thus, while Punjabi immigrant populations retain many of the symbolic forms of non-migrant Punjabis, some social norms, such as family structures, have been adjusted by migration. Some of the adaptations and adoptions of immigrant Punjabi women are not perceived as threatening, while other adaptations are commonly seen as not acceptable (Mir, 2006). Crucially though, Helweg's (1999) findings of common immigrant Punjabi cultures remains valid, suggesting that there are common transformations that take place in the process of relocating to a new country.

Traditional Punjabi family life is that of a patriarchal and collectivistic structure (Walton-Roberts & Pratt, 2005). Following the wedding, the wife moves to her husband's house and lives with the extended family of her husband, which includes her husband's parents, brothers, and their families. Traditionally, only the male members would work outside of the home. Immigration, however, can break down this structure since the economic burden on these families can create different monetary needs. Thus, often times in immigrant countries, the women are pressured through economic circumstances to work outside of the home (Bhagat et al., 2002). In addition, because of the reduced number of family members in the immigrant extended family house, the woman also experiences a reduction in the social support they would normally receive within the home (Chourdry, 2007). Another transformation in family structure that often occurs through immigration is the way in which the status of the family is determined in the new country. In Punjab, high standing is usually assessed by how much land and property is owned by the family (Ames & Inglis, 2010). Through immigration, this assessment changes to a dynamic where families that have been in the country for the longest, that have the most connections in the new country, and that have the best jobs, are held to higher standing within the communities (Walton-Roberts & Pratt, 2005).

Mayer (1959) first created a hierarchy model of respect and status to describe the immigrant Punjabi community. Highest in the model were the descendants of the earliest immigrants and their families from before

World War I who fought for the rights that successive Punjabi generations now enjoy. On the next level were the descendants of the later waves of immigrants and their families from the 1920's. On the third level were the presently active groups that had immigrated recently enough, but long enough ago that they were well established. This group, Myers wrote, was in charge of organizing and directing the cultural events. Finally, the newest immigrants, and those who were Canadian born without an influential first generation family in the area, had the lowest standing.

As the need for immigrant labor has evolved away from strictly manual labor over time, there has also been a change in the power structure due to education. This incorporation of higher education is significant because Punjabi immigrants on average have lower levels of educational achievement compared to non-Punjabi Canadian born individuals (Walton-Roberts & Pratt, 2005). This need for education ushered in a new axis of power structuring as higher levels of education begat more opportunities for employment. However, the economic disparities for newly immigrant families serve as barriers to reaching higher educational levels.

Recently, Ames and Ingles have found that Punjabi immigrants conceptualize family life in Canada by three different categories (2010): 1) what Punjabi immigrants believe that family structure and values should be in Punjab; 2) what Canadians' family structure and values are; and 3) what their own adjusted family structure and values should be in Canada. Some opinions voiced by participants in this study were that women have individual freedoms to an extent that may be detrimental for successful marriage dynamics, and that as a result, families now seem more disjointed. This research is enlightening for outlining some of the complicated dynamics Punjabi women face in raising children within a Western culture. Studies have found that these women are often at odds with what they believe to be acceptable for themselves and their children in a Western country, and with what is prescribed by tradition and their husbands to be acceptable (Foner, 1997). This study extended this research by illuminating the complex extended family dynamics in a Western country through the voices of immigrant and first generation Punjabi women.

This understanding of the history and cultural background of Punjabi immigrants in Canada helps to illustrate the adversities currently faced by women in these communities, which include language barriers, prejudice, and vastly reduced social support structures. In addition to those sources of dissonance and strife already discussed, a few others merit consideration. Beiser and Hou (2001) found that slow language

acquisition contributes to greater depression by preventing employment, and by increasing general distress. Levels of perceived prejudice have also been found to lead to higher levels of everyday distress and to higher rates of mental illness, including depression (Chakraborty & McKenzie, 2002; Karlsen, Nazroo, McKenzie, Bhui, & Weich, 2005). Many studies have also found correlations between reduced social support for Punjabi immigrants and higher levels of mental illness (Beiser, 1988; Furnham & Shiekh, 1993).

Sikhism, which the majority of Punjabi immigrants in Canada practice, has provided other grounds for misunderstanding and mistrust. This monotheistic religion values inner discipline and standing behind one's beliefs. The rich history of Sikhism incorporates a strong warrior culture that is often times misperceived as violent (Affeife et al., 2003). In Canada, Sikhism is prejudiced as being too violent, radical, and when it is mistaken for Islam, inherits those associated prejudices as well (Affeife et al., 2003). Researchers have noted that the visual symbols of the turban, the dagger, and other important Sikh religious objects influence non-minority groups to negatively view Punjabis as "most resistant to assimilation" (Affeife et al., 2003). All together, these factors form a broad picture of the adversity collectively faced by the Punjabi communities in Vancouver, and more specifically, by the women in these communities.

Depression

As previously discussed, particular histories yield unique and fluid sociocultural formations. Attending to these issues, among other things, allows for a contextualized understanding of how broader social forces, community characteristics, and personal qualities interweave in order to form the adversities and resiliencies for people who belong to that group. In this case, this would include such things as the pre-migration cultural history of Punjabi Sikhs, the history of interaction between Punjabi immigrants and already resident Canadians, the dynamics of immigration lineage within the Punjabi community, and the language acquisition by the individual. Of the many negative consequences that can result from historically rooted social processes, mental illness is a universal phenomenon that can only be understood within these particular contexts. Within the category of mental illness, no greater adversity exists globally than depression (Murthy, 2001), and for this reason, it is the primary focus of this study.

Depression has been identified to be the fourth leading cause of the global burden of disease, and is expected to rise to the first leading cause by 2030 (Murthy, 2001). Studies have found that even after controlling

for suicide, depressed individuals have higher rates of mortality (Lloyd, Jenkins, & Mann, 1996), and that it is the most disabling of all mental illnesses (Wells et al., 1989). Depressive disorders are also chronic illnesses, with at least half of the afflicted individuals suffering recurring depression throughout their lives (Murthy, 2001). More alarming is the fact that depression is the most common mental disorder for minority ethnic groups (Nazroo, 1997). Consistently, women have also been found to a have higher prevalence and longer courses of depression than men in almost every industrial and nonindustrial country assessed (Piccinelli & Wilkinson, 2000). Proposed theories for the unequal gender distribution of depression include higher burdens for women with childbirth, lower economic means, less access to resources, and gender-based violence (Cooper et al., 1999; Murthy, 2001; Araya, et al., 2001a; Stark & Flitcraft, 1996). Finally, immigrant women have been found to have even higher rates of depression when compared to resident women due to higher poverty and lower education (Miszkurka, Goulet, & Zunzunegui, 2010).

Patel and Gaw (1996) point out that depression rates vary according to socioeconomic status, social support systems, and with the amount of time spent in the new country. High poverty and low education were found to be the largest risk factors for depression by Miszkurka, Goulet, and Zunzunegui (2010). Applicable models for poverty and depression examine the mutually reinforcing cycle created by these factors. Specifically, the many life stressors that arise from poverty can exacerbate depression in individuals, which then can engender a variety of new life stressors (Murthy, 2001). For example, a study following primary care patients in India found that individuals with depression spent two to three times longer in beds and hospitals and as a result missed two to three times more days of employment per year (Patel et al., 1997). The courses of depression for these patients further exacerbated the debt and poverty they were in to create a self-perpetuating cycle. These findings indicate the necessity for assessing and controlling for a variety of variables in culturally sensitive depression research.

Studies also have found that the effect of poverty can vary by perceptions of poverty. When defined by low SES or social class, poverty is strongly correlated with depression (Murthy, 2001). Interestingly, studies have also found a likelihood for more severe depression with relative poverty when compared to absolute poverty (Dohrenwend et al., 1992). Authors explain this phenomenon through cognitive comparison theory, where people are made directly aware of their comparative economic statuses to create sources of indirect stress

(Dohrenwend et al., 1992). This theory is particularly useful for conceptualizing the relative poverty of many Punjabi immigrants in Vancouver, among whom exist wide differences in socioeconomic statuses due to migration and established families. Finally, greater social support is correlated with lower depression rates, and higher social support levels have been found to correlate with lower depression even in high poverty and low education groups (Miszkurka, Goulet, & Zunzunegui, 2010).

A study by Bhui, Bhugra, Goldberg, Sauer, and Tylee (2004) found that depression was more common in the Punjabi population in Britain when compared to non-immigrants. Furthermore, Bhui and colleagues found that depression was more common in Punjabi immigrant women, more severe in those individuals that expressed somatic symptoms, and more severe in those that have been living longer in Britain (2004). This phenomenon of higher rates and greater severity of depression with more time in the country of migration has been found in many other immigrant populations as well (Patel & Gaw, 1996). Depression scores, measured by the Canadian Community Health Survey, have similarly been found to be consistently higher in Punjabi women immigrants compared to non-immigrant Punjabi women in Canada (Patten et al., 2006).

The selfhood or personhood theory can help explain the differential experience and expression of depression in different cultures (Marsella, Kaplan, & Suarez, 2002). This theory purports that sociocentric, or collectivistic, cultures have metaphorical languages and orientations that promote stronger attachment to others in that culture. This can explain why there is not an expression of isolation, helplessness, guilt, and loneliness within these cultures that is often associated with Western constructs of depression (Manson, 1995; Manson & Klienman, 1998; Kalibatseva & Leong, 2011). Instead, since identities are context-based, symptomology will most commonly be expressed in somatic and interpersonal manifestations (Marsella et al., 2002). It is also important to note, however, that though depression is usually presented by somatic complaints in collectivistic cultures, individuals are still able to identify cognitive disturbances and negative emotions when asked to elaborate their somatic symptoms (Patel et al., 1997). Since the silencing the self theory assesses for disruptions in interpersonal relationships through inequality and oppression, which is conceptualized to create vulnerabilities to depression, the theory may be even more applicable in collectivistic cultures as explained by selfhood theory. If interpersonal relationships are more salient for depression in collectivistic cultures, the constructs for assessment of depression that have been designed within a Western culture may not be applicable

to other cultures' constructs, identities, and beliefs. It is for this reason that this study aimed to validate two Western-developed scales, the Silencing the Self Scale and the Beck Depression Inventory II, for Punjabi women.

The immigrant-based experience is not one that can be reduced to a few single variables. Differential mental health outcomes occur as the result of multifarious interactions of many factors. Adding even more complexity is the reality that these factors are often mitigated and amplified in response to one another. Of the many variables that have been found to accompany depression in immigrant women, domestic violence and self-silencing are two of the most pertinent (Gill, 2004; Jack & Dill, 1992). Because of this, this study examined the interplay of both constructs in the understanding of depression for Punjabi women.

The Silencing the Self Scale

The Silencing the Self Scale (STSS) considers the significance of interpersonal relationships in the investigation of depression in women. To do so, silencing the self theory considers relationships to be integral in a women's well being, and identifies social inequality, expectations, and standards regarding gender to cause a loss in self and vulnerabilities to depression (Jack, 1991).

Wallston (1981) argued that the field of psychology is male dominated, and that there are different questions that are important for the psychology of women. Landrine (1995) furthered the scope of current psychology by emphasizing the importance of bringing cultural diversity to feminist psychology. These perspectives considered the intersections of personal and social identities on a woman's well being, and though much successful work has been done within the field of women's psychology, there is a paucity still of cultural diversity research (Crawford & Unger, 2004). This sentiment falls within a larger movement fueled by researchers calling for a cross-cultural examination of cultural norms and development rather than solely for investigations of psychopathologies (Comas-Diaz & Greene, 1994).

Silencing the self theory arose from Jack (1991) listening to depressed women and their experiences in relationships. From these data, the scale was built to reflect what was most salient to those women. The STSS is grounded in a first person voice, and identifies the voice of the "I," what the woman wants, and the "Over-Eye," the moral authority or religious sanctions that determine what the woman should do and how she should do it. Within a larger scope, silencing the self theory draws from attachment theories, relational theories, and

cognitive theories of depression (Jack & Dill, 1992). Because of these incorporations, the very wellbeing of the woman as determined from the scale is directly tied to her social, personal, and cultural contexts.

Attachment theory regards depression to be an interpersonal problem and emphasizes the importance of relationships in human development by placing focus on the impact that negative or insecure relationships have on functioning (Bowlby 1980; Laurent & Powers, 2007). Critiques have observed, however, that early attachment theories tend to ignore gender. When Jack (1991) applied attachment theory to depressed women's psychology, she identified "feminine attachment behaviors" that were prescribed by the culture and reflected women's unequal status to men. These behaviors included avoiding conflict, pleasing others, and compulsive caretaking. Finally, though the STSS draws from the attachment perspective, which tends to focus the culpability on the women (such as the case is with negative attachment styles), silencing the self theory problematizes the social context instead (Jack & Ali, 2010).

Feminist relational theorists have argued that women, because they are unequal to men, are more attuned to the quality of relationships and that intimate relationships give women a sense of self (Gilligan, 1982; Jack, 1991; Jordan, 1997). These views also consider that gender inequality creates unequal burdens for women in social contexts such as war, poverty, and victimization while their economic dependence and lack of control over childbearing further their vulnerabilities (Broadhead & Abas, 1998; Patel et al., 2001; Patel & Klienman, 2003; Brown, 2002). These unequal burdens have been hypothesized to lead to depression, and these theories emphasize that it is society, rather than an intrinsic trait, that affects the ability for women to leave damaging relationships and situations (Astbury & Cabral, 2000).

Finally, cognitive schema theory proposes that certain schemas create vulnerability and stress by leading people to interpret situations in negative ways (Hankin & Abramson, 2001). Though silencing the self theory incorporates cognitive schemas, it differs from cognitive schema theory by assuming that the cognitive schemas characteristic of self-silencing are not stable and permanent traits. Rather, silencing the self theory purports that self-silencing schemas are dependent on social context and current relationships (Jack & Ali, 2010).

The silencing the self model theorizes that women's inequality in society, and in intimate relationships, leads them to form specific cognitive schemas that direct them to subordinate their voices and actions in

relationships. These schemas are thought to also guide their negative self-evaluations (Jack, 1991). The STSS measures the cognitive schemas that affect a woman's interpersonal behaviors and experiences of self (including the "loss of self") that ultimately affect her vulnerability to depression. Importantly, the current conceptualization of the silencing the self theory explains that the avenues through which this "loss of self" occurs may differ by culture (Jack & Ali, 2010). In this way, the STSS examines the process by which culturally enforced inequality and oppression affect personal wellbeing.

The STSS has been used in approximately 100 studies, 18 countries, and has been found to be both reliable and meaningful for many populations (Jack & Ali, 2010). The four subscales of the STSS are: Externalized Self-Perception, where the woman judges herself negatively due to externally enforced standards; Care as Self-Sacrifice, where the woman puts the needs of others before her own; Silencing the Self, where the woman self-silences to avoid conflict; and the Divided Self, where the woman presents a compliant outer self while the inner self grows angry and resentful (Jack & Dill, 1992).

The STSS correlates with the Beck Depression Inventory II across numerous social and cultural contexts, with scores on both measures being highest in contexts that carry inequality, stigma, and/or oppression (Jack & Ali, 2010). For example, in the scale construction study, depression and self-silencing scores were highest for women who had the least social freedom (battered women), and lowest for women who had the most social freedom (college students; Jack & Dill, 1992). Other studies have also found consistently that women's depression is linked with anger and suppression of expression (Sperberg & Stabbs, 1998). Additionally, the STSS has been shown to correlate positively with human immunodeficiency virus (HIV) prevalence, lower rates of self-care among cancer patients, irritable bowel syndrome prevalence, eating disorder prevalence, and mortality (Jack & Ali, 2010). Finally, because of the important associations of physical illnesses and self-silencing, and the documented higher rates of multiple illnesses in immigrant populations than in non-immigrant populations, it is especially important to identify how self-silencing relates to immigrant populations.

The STSS allows for the specific identification of areas and situations in which women may have to silence, and through qualitative work, the reasons behind the silencing can be identified. The "Over-eye" (moral and societal standards) may be strengthened by various forms of entrapment such as violence, financial dependency, and poverty, while the resulting schemas of controlled expression, repressed anger, inhibited

anger, and self judgment against a standard of a "good woman" create vulnerabilities for depression (Jack, 1991; Jack & Ali, 2010). By using the STSS in cultural studies with qualitative work, researchers can identify how the meanings of silencing the self change across cultures. This knowledge can be used to apply interventions through the domains of the silencing the self theory for oppressive situations, such as within abusive relationships. Though the STSS has been applied with many international populations (Jack & Ali, 2010), it never has been used or validated for Punjabi women.

Domestic Violence

Researchers have studied the interplay between domestic violence and depression both with and without the use of silencing the self theory, and overall gender-based violence has been found to be a strong predictor of both depression and suicide attempts (Stark & Flitcraft, 1996; Astbury & Cabral, 2000). In most cases, the violence was found to be chronic, with increasing severity, and researchers have found that domestic abuse creates feelings of humiliation, inferior status, subordination, and entrapment leading to depression (Garcia-Moreno et al., 2006). Studies have further found that abused women who have higher social support scores have significantly less risk of poor mental and physical health, while other studies have found that domestic violence increases in risk with unemployment and low-income (Coker et al., 2002; Lindhorst, Oxford, & Gillmore, 2007). Finally, Vos and colleagues (2000) found that the experience of intimate partner violence puts a woman at a higher risk for poor health even greater than the negative effects of weight, cholesterol, blood pressure, alcohol, drug use, or physical inactivity.

It has been shown that domestic abuse occurs at greater rates in immigrant women, and is strongly correlated with depression (Ahmad, Ali, & Stewart, 2005; Gill, 2004). Both domestic abuse and depression in South Asian women are hypothesized to be influenced by deviation in traditional gender roles, higher poverty rates, and reduced social support networks, all issues that are exacerbated with immigration (Gill, 2004). Because these are all factors directly applicable to many of the Punjabi women in the communities the study was conducted in, this study explored many of these variables.

Domestic abuse is currently a prevalent problem in the Punjabi communities around Vancouver, and several domestic violence incidents have resulted in the deaths of the woman victim (Grewal, Bottorff, & Hilton, 2005). As a response, many social justice programs in these areas have been formed to prevent and

combat domestic violence with Punjabi women. Programs acknowledge that more information on the experience of domestic violence for these women is needed for successful interventions, aid, and accessibility of services to women (Grewal et al., 2005). By identifying the dynamics that Punjabi immigrant women have to interact within in relation to self-silencing, domestic violence, and depression, this study gives further insight for future areas of prevention and modes of intervention.

The Current Study

Anti-oppressive research involves making explicit the political practices of creating knowledge. It means making a commitment to the people you are working with personally and professionally in order to mutually foster conditions for social justice and research. It is about paying attention to, and shifting, how power relations work in and through the process of doing research (Potts & Brown, 2005, p. 255).

Just as the STSS emerged from the narratives of women, so too does this study incorporate qualitative methods to build a more complete understanding of how domestic violence, self-silencing, and depression interrelate for Punjabi women in Vancouver. A mixed methodological approach was best suited to reveal the complexity of experience and sociocultural context relevant to these issues (Johnson & Onwuegbuzie, 2004). For this reason, this study utilized a combination of key informants, focus groups, and scale analysis to build a triangulated, multifaceted, and nuanced understanding.

Principled cultural sensitivity explicates a cultural perspective on risks and benefits of the studies for participants, culturally respectful informed consent and confidentiality, and community and participant solutions for the issues under investigation. The purpose of research should be for community development, or lead to findings that can be used as a resource for the community (Tricket, Kelly, & Vincent, 1985; Tricket & Birman, 1989). Furthermore, culturally sensitive research should not further pathologize groups (Trimble & Fisher, 2006). All of these considerations were guiding principles in the processes of this study.

In concordance with core methodological principles of ethnographic research, Bhui et al. (2004) has highlighted the importance of having key informants while conducting sensitive research with Punjabi populations. These informants are members of the community of interest with whom the researcher mutually collaborates and is able to ask questions specific to the culture of that community. The authors also stress that many times, sentiments expressed by participants may not translate across cultural divides, and that often times

a key informant can bridge the gap of communication. For example, Punjabi culture has been found to describe distress and depression through somatic, emotional, cognitive, and spiritual explanations of a "sinking heart" (Krause, 1989). Idioms of distress such as these cannot be identified and correctly translated without asking the proper questions, or without knowing the correct conceptual translations. For these reasons, the current study was planned with the input and collaboration of many Punjabi community members. Data collection, analysis, and dissemination of the results followed with these close collaborations as well.

Bhugra and colleagues (1997) have found focus groups to be most effective in assessing accurate feelings and practices associated with mental health with Punjabi women. Lawrence and colleagues (2006), also through focus groups, identified important themes to ask Punjabi participants regarding depression: what a person with depression should do, what they would need in terms of help, who should help them, and under what circumstances would each of these dimensions change. The authors further reported that the use of open questions such as this facilitated the expression of the most amount of information concerning depression. Questions asked of the participants regarding depression in the current study were derived from this open-ended approach.

The current study involved Punjabi women, the majority being immigrants. All participants took the Silencing the Self Scale, the Beck Depression Inventory II, and a demographic questionnaire that included an assessment for the experience of domestic violence. Additionally, participants participated in focus groups of five to 10 women to discuss the STSS items and questions surrounding depression. Commonly, the Beck Depression Inventory II is used in depression research and diagnosis in the United States and Canada. Even in the most culturally sensitive constructed studies, scales used to measure depression are still derived from Western constructs. Without validation, results from the specific culture being surveyed may not be meaningful. For all of these reasons, the use of the STSS and BDI-II in this population was balanced by focus group input for the validation process to properly reflect the cultural background of participants. As a result, this study helps to illuminate a Canadian-Punjabi view to give insight into whether our common mental health assessment tools are sensitive to the particular type of emotional suffering of people within this population.

Research Questions and Hypotheses

Since a large portion of the study was exploratory in nature, it was not possible to formulate many hypotheses *a priori*. Rasch measurement analysis is a statistical technique that allows researchers to compare individual participant performances on items with their overall performances on scales (Bond & Fox, 2007). Rasch analyses can identify items in both the STSS and BDI-II that do not fit for this population. It is of particular interest to see if specific questions from the STSS and BDI-II do not apply to this population due to their Western developed origins. Any poor fit items can be interpreted to have a different conceptual meaning for this population, and the interview data can be called upon to help understand the poor fit.

The following hypotheses were predicted *a priori*:

1) It was predicted that Punjabi immigrant women would score higher on the STSS and the BDI-II when compared to past data on these measures of non-immigrant women from the original study by Jack & Dill (1992). This was expected to be true due to conflicting gender role expectations for the women, assimilation pressures, reduced social support, and other stressors for which immigration may be a proxy.

2) It was expected that the experience of domestic violence would be a significant predictor for STSS and BDI-II scores. Specifically, higher overall scores for the BDI-II and STSS were expected to associate with the presence of domestic violence in the woman's past, as this has been observed in past research with other populations (Jack & Ali, 2010).

3) BDI-II scores and STSS scores were expected to be highly correlated, as found in previous research (Jack, 1991; Jack & Ali, 2010). Specifically, higher overall BDI-II scores were expected to be associated with higher overall STSS scores.

Method

Participants

Fifty-five self-identified Punjabi women from a city near Vancouver, B.C. volunteered to participate in the study. Women were recruited from six different social service groups (two English advancement classes and four parenting groups). An analysis of variance (ANOVA) for the Silencing the Self Scale (STSS) group means ($F(5, 49) = 1.08$, $p = .38$) and Beck Depression Inventory II (BDI-II) group means ($F(5, 49) = 0.87$, $p = .51$)

indicated that the means for each of the six groups were not significantly different from one another, so the data from the groups were combined into one group for further analyses.

Of the participants, 74.50% indicated that they had been born in India, 16.40% in Canada, and 9.10% from other countries (Fiji, Malaysia, South Africa, and Singapore). Though the original design of the study was conceptualized with only immigrant Punjabi women, many immigrant and first generation Punjabi women objected to this stipulation. Punjabi women from the community voiced that the cultural reasons that lead to depression and self-silencing are shared among immigrant and first generation women. For these reasons, interested women that were first-generation were also included in the study. Here first generation is defined as women who were born in Canada. For the 83.60% of women that had identified themselves as immigrants, the average amount of time since immigration was 19.33 (12.92) years. The women were also asked to fill out religious affiliation and 65.50% self-identified as Sikh, 9.10% as Hindu, and 21.80% left this portion blank.

The mean age of the women was 41.37 (13.33) years. The women had an average of two children (range from zero to five), 74.50% were married, 20.00% were separated, 3.60% were divorced, and 1.80% were single. Information about employment and education was also collected. Fifty one percent of the women were employed and 45.50% were unemployed. Finally, 9.10% had not completed a high school degree, 20.00% had completed only a high school degree, 49.10% had completed undergraduate education or technical school, and 9.10% had completed some form of graduate degree.

Additionally, the women were asked some personal safety and social support questions at the end of the demographic questionnaire. For the question assessing social support, 27.30% of the women indicated that they did not feel like they had someone with whom to talk, and 69.10% indicated that they did. For personal safety questions, 32.70% indicated that they had felt unsafe in their homes at some point (63.60% indicated that they had never felt unsafe in their homes), 45.50% indicated that they had been subjected to verbal abuse from their partners (49.10% indicated that they had not been subjected to verbal abuse), and 26.90% indicated that they had suffered physical abuse from their partners (69.10% indicated that they had not suffered physical abuse). The information provided by the women about friend support, physical abuse, and verbal abuse was used in subsequent Chi-Squared, ANOVA, and ANCOVA analyses.

Measures

The Silencing the Self Scale (Jack & Dill, 1992; Appendix A). The STSS is a 31-item measure. Response choices range from 1 (*strongly disagree*) to 5 (*strongly agree*). Scores can range from 31 to 155, with higher scores indicating higher levels of self-silencing. There are four theoretical subscale measures in the scale: Externalized Self-Perception, Care as Self-Sacrifice, Silencing the Self, and the Divided Self. Example questions are "considering my needs to be as important as those of the people I love is selfish," and "I don't speak my feelings in an intimate relationship when I know they will cause disagreement." The scale has been validated to have good construct validity, Chronbach's alpha measures of .86 to .94, and re-test reliability of .86 (Jack & Dill, 1992).

The Beck Depression Inventory II[1] (Beck, Steer, Brown, 1996). The BDI-II is a 21-item depression assessment tool. Response choices range from 0 to 3. Total possible scores can range from 0 to 63, with higher scores indicating greater depression levels. Internal consistency, internal validity, test-retest reliability, and construct validity of the scale have been found to be good and consistent in past studies (Dozois, Dobson, & Ahnberg, 1998).

Demographics Questionnaire

Other variables assessed in the demographic questionnaire were age, ethnicity, place of birth, time since immigration (if applicable), marital status, employment status, religion, education levels, and number of children. Social support was assessed by a question asking if the woman had a friend or group of friends to discuss personal matters with. Domestic violence status was assessed by questions assessing experiences of verbal abuse and physical abuse.

Focus Groups

The focus group script asked participants to provide feedback for items grouped into the four subscales of the STSS based on their experiences. The script also asked women to respond to three questions about depression based from their experiences. The questions were: "How do you, or people you know, experience depression? What do you think led up to this depression? What do you think could help combat this type of depression?"

[1] Due to copyright restrictions, the Beck Depression Inventory II cannot be reproduced. Copies of the scale may be obtained from www.beckscales.com.

Coding. Focus group sessions were recorded and transcribed verbatim by the main author. Thematic coding was utilized for the analysis of the focus group data. The thematic analysis incorporated a data-driven inductive approach (Boyatzis, 1998) and a resulting deductive approach utilizing template codes (Crabtree & Miller, 1999). First transcripts were read and codes were assigned to each line of script. As the transcripts were read and re-read, codes were categorized into larger inductively driven thematic categories. Next, the researcher and three other team members created template codes from the inductively driven codes. From this initial reduction of data, 17 template codes grounded from the data were included into the coding manual. These codes were combined with, or collapsed into, the *a priori* codes that included instances for each of the four Silencing the Self Scale subscales, and the three depression questions that were asked of the participants. The coding manual had a name for each code, a description of the code, and examples of how to identify the code in transcripts (Appendix B).

Two researchers recoded the data with the use of the coding manual, and reliability was ensured through the discussion of non-similar codes. If a consensus could not be reached for the code, that instance of the code was dropped. Analysis of the data was guided and not confined through the use of the template codes. Throughout this iterative coding stage, a constant summarizing and identification of larger themes occurred with the entire research team. Finally, the codes were connected if possible, and themes were identified from this iterative process of discovering themes and patterns. All qualitative analysis was done with the use of QSE NVivo (8) for data management.

Procedure

The participants were greeted and welcomed upon entering the study room. After giving signed consent, the participants were given the Silencing the Self Scale, the Beck Depression Inventory II, and the demographic questionnaire to fill out individually. The order of STSS and BDI-II in the packets given to participants were counterbalanced to avoid potential priming confounds. After completion, the scales were collected, and papers were given to the participants with the Silencing the Self Scale questions separated by subscales, but not identified by name.

The participants were then given a set of verbal directions following the prepared script that had been adapted from a study by Ali (Ali & Toner, 2001). The participants were asked to look at the first group of

questions and to reflect on how these thoughts and ideas relate to their lives in Vancouver. Participants discussed as a group what the group of questions meant in relation to their lives until no new themes or thoughts arose. The same procedure was followed for groups two, three, and four of the scale. At no point were the participants told the formal names of the subscales.

After the discussion of the fourth subscale, participants were asked three questions about depression. The questions were: "How do you, or anyone you know who has depression, experience depression? What do you think led up to this depression? What do you think could help combat this type of depression?" Each question was discussed until no new themes arose. Focus group discussions were recorded with the use of two audio recorders, and lasted approximately for two hours. Upon completion of the last question, participants were given a debriefing form and time to discuss the study with the researcher. Compensation was provided in the amount of $25.00 Canadian dollars for each woman.

Results

Quantitative and qualitative data were collected from the study. In the following section, first a brief overview is given for Rasch measurement analysis. The background information provided outlines the criteria used to evaluate the Rasch measurement output for the Silencing the Self Scale (STSS) and the Beck Depression Inventory II (BDI-II). Following the Rasch measurement analysis background are the quantitative results. Descriptive statistics on the scales henceforth called the "raw data" are provided so that the results may more easily be compared with past STSS and BDI-II studies. Results from the Rasch measurement analysis follow the "raw data" results. Finally, results from the coding of the focus group data are given to give context for the quantitative findings.

Rasch Measurement Analyses Background

The following review of the Rasch measurement model is to give readers the conceptual background for evaluating the Rasch measurement output and following data calibration decisions made based on the output. Included in the review are the parameters used to assess good precision, reliability, fit, and response category usage for the STSS and BDI-II items. The Rasch model is a one-parameter item response theory model that produces summaries of individual performances for a construct (Bond & Fox, 2007). Individual scores for individual items are also compared to an ideal model where an algorithm is incorporated that expresses the

probabilistic expectations of item and person performances when one unidimensional construct is held to underlie the developmental sequence (Wright and Stone, 1979).

The extent to which the item and person estimates adhere to the Rasch model expectations demonstrates the extent to which the scale is measuring a unidimensional construct. Unidimensionality does not mean that there can only be one psychological process underlying the processes required to fill out the rating scale. Rather, unidimensionality reflects that the item performances are influenced by a variety of processes in the same manner (Bond and Fox, 2007). In other words, the test of unidimensionality is satisfied by fit measures that Rasch analyses provides. If the fit indices reflect good fit, then the test of unidimensionality is met and the scale can be said to have good construct validity (Bond and Fox, 2007).

The Rasch measurement analysis orders items from least likely to endorse, to most likely to endorse based on actual performances. Similarly, participants are ordered based on overall scores from the least amount of the construct (Self-silencing or depression) to the most. In this fashion, item "difficulties," or the probability it will be endorsed, and person "abilities," or the amount of the construct the person has, are calculated. The less an item is endorsed, the more "difficult" it is and the more consistently a participant endorses items of the tested construct, the higher her "ability" is considered to be.

If the data reflect a successful theory guided measure, we expect that persons who self silence more, or are more depressed, will have a greater likelihood of endorsing items in the STSS or BDI-II, overall. Of the items that are more likely to be endorsed ("easier" items), we would expect most participants to endorse these items in a successful measure. Of the items that are less likely to be endorsed ("difficult" items), we would expect only those that are more likely to self-silence, or that are more depressed (higher overall scores), to endorse these items in a successful measure. If the expected pattern is not apparent, it may indicate that the item that is not aligning with the expected pattern may not be measuring the construct successfully. For example, if people with lower levels of the construct endorse more "difficult" items, those items would warrant further investigation. Conversely, if people demonstrating higher levels of a given construct do not endorse "easy" items, those items too would warrant further investigation. In short, Rasch theorem states how people and items should perform in a perfect measurement world (Bond & Fox, 2007).

The Rasch rating scale model output provides an *estimate* and associated error for each item and person. *Item estimates* reflect different relative levels of endorsability ("difficulty") while *person estimates* reflect different relative levels of the construct for each person ("ability"). A well-designed rating scale should have items at all levels of endorsability. This variety allows a single rating scale to identify persons with all varying levels of the construct. For example, a high item estimate indicates that an item is well suited to assess levels of the construct in people that have high levels of the construct.

Another aspect unique to the Rasch measurement model is the construction of an interval scale for Likert scales. Polytomous data, or Likert scale ratings, are subjective by nature. If measuring a trait, such as depression, some questions may be worded so that agreeing with one item with a response of "*strongly agree*" may indicate a higher level of depression than giving the same response "*strongly agree*" to a different question. Utilizing the Rasch measurement model with Likert scales allows each item to indicate a different level of construct by the estimates provided (Bond & Fox, 2007). To do this, Rasch analysis results in reports of person estimates, estimates for each item, and one set of rating scale thresholds common for all items.

The actual item and person performance probabilities determine the interval size to transform ordinal data into true interval data. Rasch measurement algorithms calculate item endorsability and person construct level estimates using raw score proportions. At this stage of the analyses the data are still nominal, and not interval. These raw score proportions are what are usually analyzed in standard rating scale analysis (Bond and Fox, 2007). The proportions, however, do not acknowledge that earning points by endorsing a question that has been found as more difficult to endorse empirically reflects more of the construct than endorsing a question that is easier to endorse. In a test taking example, this would be analogous to a student earning the same amount of points for getting an easier question correct as they would for getting a very difficult question correct. Through logarithmic transformation, the raw scores are changed into success to failure odds, and finally into log-odds or logits. This wider distribution more accurately represents accurate increases in the construct (Wright & Linacre, 1989). To construct these interval measures the Rasch software utilized for this study was Winsteps.

Estimates and Imprecision. Item estimates of endorsability ("difficulty") and person estimates of levels of construct ("ability") are displayed in the output on the logit scale (log odds unit scale). A value of "0" is arbitrarily set as the total mean for the item estimates in Winsteps. Negative values represent easier to endorse

items, while positive values represent items more difficult to endorse. The total person ability mean is estimated in relation to item difficulty. Positive person mean estimates indicate that the sample has persons with more of the construct than the scale can effectively differentiate, and negative mean values indicate persons with less of the construct than the scale can effectively differentiate (Bond & Fox, 2007). The Rasch model sets 50% as the probability of success for any person on an item located on the same value on the logit scale. The single estimate given for each item models the point at which the highest and lowest response categories are equally probable, as well as the number of persons endorsing those response categories (Bond & Fox, 2007). In this way, the Rasch model output demonstrates which items will most likely be endorsed by people that have high, medium, and low levels of self-silencing and depression (Bond & Fox, 2001).

The mean estimate for all items and the mean estimate for all persons should be very similar for a well-targeted rating scale. If the scale is "well- targeting," or the mean estimates for persons and items are similar, the rating scale can be said to be a good scale for identifying the construct under question in the sample. Stated another way, a scale is considered to be appropriate for a given population if the "difficulty" of the scale closely matches the "ability" of the group. A scale that is too difficult or too easy for a given population will not adequately discriminate among participants as their responses will be too closely clustered.

The precision of estimates is shown by the error associated. Larger item estimate error values can result if participants are not likely to endorse the item at all. This may mean that the item is not applicable for this sample. Person estimates may have large errors if those participants are not likely to endorse any items and can indicate that the scale is not sensitive enough to measure the construct for this individual. A well-targeted test (a similar range of estimates for persons and items) will have the least amount of imprecision associated with the estimates. However, the extreme ends of scales are the most prone to error, and so the items that are hardest to endorse often have the most associated error (Bond & Fox, 2007).

Reliability. Rasch output provides reliability values that are interpreted in the same way Chronbach's alphas are interpreted. The *person reliability index* indicates the replicability of the same person distribution if the sample of participants were given another parallel set of items measuring the same construct (Wright & Masters, 1982). This reliability is enhanced by a large variability in the levels of the construct that participants

have, a longer test, more response categories, and good person-item targeting. This reliability statistic is independent of sample size.

The *item reliability index* demonstrates the replicability of the item estimates if given to another sample with same size and behavior. This index is enhanced with more people at every construct level, a wide range of item difficulties, and a larger sample size. Both reliability indices are also reported as a *separation index* that indicates the number of standard errors of spread among the items (Fox & Jones, 1998). Both these values refer to the ability of a test to define a distribution hierarchy of items along the measured variable. Generally, higher numbers indicate more confidence in the replicability of item placement across other samples.

Fit. Fit statistics determine whether the item estimates can be regarded as meaningful quantitative summaries of observations, and whether each item contributes to the measurement of one construct. They show the extent to which responses conform to the expected pattern of responses and provide researchers with the measure's validity for each participant to illustrate which specific items may be biased or misinterpreted (Smith, 1991a). Rasch output provides both Infit and Outfit fit statistics. *Infit fit statistics* give more weight or influence to persons closer to item values, and *Outfit fit statistics* are unweighted and are more influenced by outliers.

Fit statistics are reported in both an unstandardized form and a standardized form. The unstandardized form is the mean squares average of the residuals between the Rasch modeled expected item performances and actual performances. These fit statistics should equal one under Rasch measurement modeled expectations. Standardized fit statistics are provided in the form of t-scores. These fit statistics should equal zero under Rasch measurement modeled expectations. Generally, unstandardized fit statistics with values between 0.60 -1.40, and standardized fit statistics of -2.00 – 2.00 are accepted for Likert scales (Bond & Fox, 2007). These guidelines are not meant to be cut-off points, however, and theory should be taken into account in any decisions for dropping items (Smith, 1999a). Finally, because negative fit values (*overfit*) indicate redundancy and a lack or variation, they are not as alarming as positive fit values (*underfit*) indicating unexpected performances.

Response Categories. As aforementioned, Rasch measurement analysis transforms ordinal data into true interval scales. There exists one *Rasch-Andrich threshold* between any two possible consecutive responses. For example, in a Likert scale with five response options (e.g., *strongly disagree, disagree, neutral, agree,*

strongly agree), there exist four thresholds. This is the level at which the likelihood of being observed in a given response category (below threshold) is exceeded by the likelihood of being observed in the next higher category (above threshold). "Success" signifies an endorsement of a category, and "failure" signifies a failure to endorse. The Rasch measurement output indicates that these thresholds are not separated equidistantly for any given scale, and that some steps between thresholds require smaller increases of the trait than others. The pattern of final calculated thresholds, however, is identical for all items.

The Rasch rating scale model requires that every item in a set has the same number of response categories, however, all the response categories may not be used in practice. Rasch rating scale output provides *category frequency counts* that indicate how many respondents chose a particular response category. These counts are the summed endorsements for each category across all items. Each response category should have at least 10 endorsements per category, and low frequencies do not provide enough observations for the estimation of stable threshold values (Linacre, 1999a). In examining the distribution of category frequencies, a well-designed scale will have either a uniform, normal, bimodal, or slightly skewed distribution. An irregular or highly skewed distribution indicates that the rating scale categories are not being used as expected.

The *observed average measures* given for rating scale categories are the averages of ability estimates for all participants in the sample who chose that particular category. Like the frequency counts, these averages are calculated across all observations in that category. For a well-designed rating scale, the average measures should increase monotonically where those with less of the construct should endorse the lower categories (*strongly disagree*) and those with more of the construct should endorse the higher categories (*strongly agree*). A lack of monotonicity may indicate that participants are not using the response categories in a logical order, that there may be too many categories, or that the categories are labeled in a confusing manner. Rasch measurement output also provides *expected averages*, which are the Rasch measurement modeled expectations for the actual empirical data. Large discrepancies between the observed and expected averages indicate unexpected use of the response categories.

Structure measure (also known as step difficulty, step calibration, Tau, or Delta) output indicates the calibrated measures for the transitions from one response category to another. These values show the difficulties estimated for choosing one response category over another, and demonstrate the magnitude of distances

between adjacent threshold estimates. These estimates should also increase monotonically, and disordered estimates indicate that the category is rarely observed for the construct. The values should also indicate that each threshold is distinct in a well performing rating scale by thresholds that increase by one to five logits (Linacre, 1999a). Finally, the Rasch measurement output also provides the approximate standard error for each Rasch-Andrich threshold and fit statistics. Infit and Outfit mean squares greater than 2.00 (*underfit*) indicate that there is more misinformation than information in the category, and that it should be collapsed (Linacre, 1999a). Values less than 2.00 mean squares show fit of each rating scale category to the unidimensional Rasch model.

Response categories can also be plotted graphically as response probability curves. The x-axis indicates the difference between the ability estimate and difficulty estimate, where higher numbers indicate more ability compared to difficulty (higher probabilities of item endorsement). The y-axis indicates the probability item endorsement. Zero logits on the x-axis indicates the point at which the highest and lowest categories are equally likely to be observed. For a well performing scale, each response category should have its own distinct peak which illustrates that the category is the most probable response for some portion of the construct. Categories that do not have a peak indicate disordered Rasch-Andrich thresholds. Flat categories of the measured construct, however, may still be useful if spanning a large enough portion of the construct. Threshold estimates given for the response categories are shown as the intersection between the categories, and indicate the point at which there is an equal probability of choosing either of the two categories.

Raw Data Statistics

Raw data statistics are included so that the data from this study can be compared to data collected in other studies that have used the STSS and BDI-II. Statistical analyses were only conducted with the Rasch measurement calibrated measures for STSS and BDI-II scores, and were not conducted with raw data summaries.

Table 1 shows the total participant means, standard deviations, minimums, and maximums for the STSS, the four subscales, and the BDI-II. The mean for the STSS overall was 94.78 (24.18). The STSS means for those women who reported verbal abuse was 108.55 (14.10), for those women who reported both verbal and physical abuse was 108.86 (23.88), and for women who reported no abuse was 81.38 (20.32). The BDI-II

means for those women who reported both verbal and physical abuse was 25.43 (16.18), for those women who reported verbal abuse was 16.82 (10.63), and for those women who reported no abuse was 5.58 (1.05).

The STSS means for immigrant Punjabi women born in India was 103.29 (23.80), for immigrant Punjabi women from other countries was 82.60 (14.21), and for Punjabi women born in Canada was 60.00 (16.34). The BDI-II means for immigrant Punjabi women born in India was 15.54 (14.02), for immigrant Punjabi women from other countries was 8.00 (7.81), and for Punjabi women born in Canada was 4.56 (2.55). Again, it should be noted that there were much fewer participants in the "other" and "Canada" groups than the "India" group.

As seen in Table 2, the Chronbach's alpha reliabilities for the STSS and BDI-II scales were excellent at .94. The reliabilities for three of the STSS subscales, the Externalized Self Perception (ESP), the Silencing the Self (SS), and the Divided Self (DS) subscales, ranged from .81 - .85. The Care as Self-Sacrifice (CSS) subscale, however, had a questionable reliability of .67. Table 3 shows the inter-item correlations for the CSS subscale, and the STSS items can be found in Appendix A. Six pairs of items gave unexpectedly negative correlations. Issues with the CSS subscale were also specifically investigated with Rasch measurement analyses. Correlations between the four subscales were high and ranged from .601 to .870 (all correlations were significant at $p < .01$) as shown in Table 4.

The correlations between the BDI-II and the ESP, SS, DS, and CSS subscales were .68, .49, .56, and .48, respectively (all correlations were significant at $p < .01$). Finally, the correlation between the uncalibrated STSS and BDI-II scores was also very large, $r = .625$, $p < .001$.

Rasch Measurement Analysis of Silencing the Self Scale Data

As seen in Figure 1, the distribution of item and person estimates for the STSS was relatively well matched. Item estimates were more tightly clustered around the arbitrary item mean of zero than the person estimates, however, and there were no items with endorsability estimates above .6 logits. This relatively well-matched targeting and close clustering of observations for the item estimates was corroborated when examining the summary item and person statistics in Table 5. As always, the estimate mean for items was set arbitrarily to zero by Winsteps (SD = 0.36), and the corresponding person mean of -.01 (0.67) indicated a very well matched test. The deviations around the estimate means showed, however, that the person estimates were much more

spread out than the item estimates. This demonstrated that the items gave more information on the participants than the participants gave on the items. The fit statistics for both the item and the participant means were well within the acceptable range. Finally, the reliability and separation statistics for the items (.86 and 2.5) were very good, while the reliability and separation statistics for the participants (.91 and 3.09) were even better. The high reliability and separation statistics for participants indicated that the test separated participants into more than three different levels, and that the person distribution observed would be replicated with a parallel set of items. The reliability and separation indices for the items indicated that the sample that took the test separated items into more than two levels for the levels of the silencing the self construct it can assess.

Item estimates and fit statistics can be found in Table 6. Item estimates ranged from -1.60 logits for question number 12, “One of the worst things I can do is to be selfish,” to .60 logits for questions 11, “In order to feel good about myself, I need to feel independent and self-sufficient,” and 22, “Doing things just for myself is selfish.” This range indicates the need for more items that assess higher levels of the construct. This skewed range of construct sensitivity in items may be remedied by the development of more items, or by the development of response categories that indicate higher levels.

As Table 6 shows, the following items were found to be misfits according to the output (mean squares Infit and Outfit values over 1.4, or t-standardized values over 2.00): item 1, “I think it is best to put myself first because no one else will look out for me,” item 3, “caring means putting the other person's needs in front of my own,” 11, “in order to feel good about myself, I need to feel independent and self-sufficient,” 12, “one of the worst things I can do is to be selfish,” 15, “I speak my feelings with my partner, even when it leads to problems or disagreements,” 20, “when it looks as though certain of my needs can't be met in a relationship, I usually realize that they weren't very important anyway,” and 22 “doing things just for myself is selfish.” Questions one, three, 11, 12, and 22 were all from the Care as Self Sacrifice subscale, while questions 15 and 20 were from the Silencing the Self subscale. Item 1 was the most misfitting of the items with its Infit fit statistics indicating 126.00% more variation than was expected, and its Outfit fit statistics indicating 309.00% more variation than was expected. These high percentages of unexpected variation indicated the high degree to which participant performance on item 1 did not align with Rasch measurement model expectations.

Table 7 displays the response category diagnostics for the STSS. The observed count column shows adequate usage of each category (more than 10 counts) by participants. An examination of the distribution of response category endorsement in Figure 2, however, shows that the "somewhat agree" category was used considerably more than the other categories. The observed average column in Table 7 shows that the average construct estimate of participants that endorsed each response category does increase monotonically as expected. These values are also shown in Figure 5. Additionally, the observed average estimates were very close to the Rasch modeled expected average estimates for the data. The Infit and Outfit mean squares fit statistics were under 2.00 for all response categories, and were considered adequate fit.

The structure measure values in Table 7 indicate also that the response category "strongly agree" was problematic. These values should increase monotonically, however, the output shows that it was much easier for participants to choose "strongly agree" than either of the three response categories before it. This disordering of category estimate shows that "somewhat disagree," and "neither agree nor disagree" were much harder for participants to utilize for this construct. Additionally, the separation between the categories is not as much as expected for well functioning rating scale categories (by at least 1 logit) and further confirms that the categories were not used by participants as they were expected to. Figure 3 demonstrates graphically the disordering of response categories. Response categories "somewhat disagree" and "neither agree nor disagree" do not have a distinct peak in the in graph of response category probability curves showing that neither of those categories had a modal peak of endorsement for any part of the measured construct.

These response category diagnostics together indicate the misuse of both the "somewhat disagree" and "neither agree nor disagree" categories by participants where the category of "somewhat agree," was easier for participants to endorse than the categories "somewhat disagree" and "neither agree nor disagree." This suggests that the response categories of the scale are not being used as intended. Linacre (1999a) advises that the item and person estimates in the case of disordered thresholds cannot be taken literally because the disordering indicates a logically non-interval measure, and advises that the collapsing of the categories would be appropriate.

Care as Self Sacrifice Subscale. Because many of the misfitting items from the Rasch measurement model analysis of the STSS were from the Care as Self Sacrifice subscale (CSS; items 1, 3, 11, 12, and 22), a

Rasch measurement model analysis was conducted on the CSS items alone. This was done to see if any of the misfitting items from the original analysis also did not fit as a member of the unidimensional construct of CSS. Figure 4 displays the item and person estimates for the CSS analyses. As is expected, there was a much smaller distribution of items because of the vastly reduced number of items. As Table 8 shows, however, the total person mean of .03 (0.58) logits was very close to the arbitrarily set item mean of 0.00 (0.47). This indicated that the CSS subscale items were well targeted for this sample. The fit statistics in Table 8 also indicated good model fit of the mean item and person performances. Additionally, by analyzing the CSS items separately, the item separation and reliability statistics increased in value from the original STSS analysis (Table 8). The person reliability and separation statistics for the CSS items alone were also higher than the statistics for the STSS all items analysis. This increase in reliability for when the CSS was analyzed alone indicated that participants might have been endorsing CSS items as part of a separate construct.

The item estimates and fit statistics can be found in Table 9. The only misfitting item when the CSS was analyzed separately was item one, "I think it is best to put myself first because no one else will look out for me." This item was shown to not fit the unidimensionality requirement for Care as Self Sacrifice by having 58.00 % more variation than expected as indicated by its Infit fit statistics, and 83.00 % more variability than expected as indicated by its Outfit fit statistics. The item characteristic curve shown for item one in Figure 5 demonstrates the extent to which participants' endorsement of item one was unexpected. The "expected" line indicates the expected performance of the item, while the "empirical" line, indicating actual performance, demonstrates how far outside of the control lines for expected performance participants' actual performances were.

Table 10 displays the response category diagnostics for the CSS items. The observed count column indicates an adequate amount of usage for each response category. The distribution of response category endorsement shown in Figure 9, however, reveals the disproportionate use of the "strongly agree" category again. The observed average values increased monotonically as expected (Figure 6), and were very close to the Rasch modeled expected average estimates. Finally, the fit statistics for the categories had adequate fit.

As expected due to the over-endorsement of the "strongly agree" category, the structure measure values indicated that the "strongly agree" category was disordered. It was easier for participants to choose

"strongly agree" on this subscale than it was to choose the two response categories, "somewhat disagree," and "neither agree nor disagree." The separation between category thresholds is under one logit and further confirms that the categories were not used as expected. Finally, Figure 7 demonstrates that the response categories "somewhat disagree" and "neither agree nor disagree" probability curves did not have distinct modal peaks indicating that neither of the categories had the highest probability of being endorsed for any part of the measured construct.

Rasch Measurement Model Analysis of BDI-II Data

The distribution of item and person estimates can be seen in Figure 8. The item estimates were tightly clustered around the mean of zero, while the person estimates were much more spread and skewed towards the negative end of the logit scale. The person estimate mean of -1.54 (1.26) indicated that there were much more negative person estimates and a higher degree of variability than the item estimates with a mean of 0.00 (0.42), as shown in Table 11. This indicated that the BDI-II was not a well-matched test for this sample, and that many of the items were not sensitive enough to assess for levels of depression. Finally, the fit statistics for the item and person estimates means indicate adequate fit.

The reliability and separation statistics for the items (.69 and 1.5) were mediocre and indicated that the sample did not separate the level of depression assessed by items into more than one group. These statistics show that the sample that took this measure did not have widely varying levels of depression, as assessed. The person reliability and separation statistics (.83 and 2.18) demonstrated that the test separated participants into about two different levels, and that the person distributions observed would be replicated with a parallel set of items.

Table 12 shows the item estimates and fit statistics. Item estimates ranged from -0.66 logits for item 17, which assessed tiredness, to 0.71 logits for item 19, which assessed weight loss. This range indicated the need for more items that assess for both higher and lower levels of depression in this sample. This narrow range of construct sensitivity in items may be remedied by the development of more items, or by the development of response categories that allow for the endorsement of lower and higher levels for each item. Item 2, which assessed for hope for the future, item 10, which assessed for amount of crying, item 14, which assessed for perception of looks, item 16, which assessed for amount of sleep, and item 19 which assessed for weight loss

were found to be misfitting items (Table 12). Item 19 was the most misfitting of the items with its Infit fit statistic indicating 160.00 % more variation than was expected, and its Outfit fit statistics indicating 579.00 % more variation than was expected.

The response category diagnostics can be found in Table 13. The observed counts showed adequate counts of usage for each category. As can be seen in Figure 9, the distribution of response category endorsement decreased incrementally from zero to three, with only 78 people endorsing category three. The observed average values in Table 13 indicated that the average construct estimate of participants that endorsed each response category did increase monotonically as expected. Additionally, the observed average estimates were very close to the Rasch modeled expected average estimates for the data, with the exception of categories two and three for which observed and Rasch modeled expected values were apart by .10 logits. This disparity indicates the need for further examination of response categories two and three. Finally, the Infit and Outfit mean squares fit statistic values were lower than 2.00 for all response categories, except for category three that had an Outfit mean square value of 2.69. Values over 2.00 demonstrate inadequate response category fit to the Rasch modeled expectations and should be collapsed into adjacent categories (Linacre, 1999a). The structure measure values in Table 13 showed the expected monotonic increases in values, but indicated a lower separation between thresholds than expected. This lack of separation also indicated that response categories were not utilized as expected. Figure 10 demonstrates that both categories one and two lack separation between their probability curve peaks of endorsability, which further indicates problematic category usage.

Calibrated Measures for the Silencing the Self Scale

The Rasch measurement analysis of the STSS scores indicated that the "*somewhat agree*" category was considerably easier to endorse than the "*somewhat disagree*" and "*neither agree nor disagree*" categories. This was shown by the response category distribution and by the structure measure values. Because these results indicated that the response categories were not being utilized in a logical order consistent with theory, the "*somewhat disagree*" category was collapsed into the "*strongly disagree*" category, and the "*somewhat agree*" category was collapsed into the "*strongly agre*e" category. These decisions were made in order to remedy the inconsistent response category findings and to preserve the logical order of the response scale.

After the collapsing of the two categories, the number of misfitting items was greatly reduced. Only item 1, “I think it is best to put myself first because no one else will look out for me,” with a Infit mean square value of 2.38 and item 22, “doing things just for myself is selfish” with a mean square value of 2.10 were still misfitting items. This reduction of misfitting items indicated that much of the cause for the misfit items was due to the unexpected use of response categories. After the dropping of items 1 and 22, the resulting output indicated that item 24, “I rarely express my anger at those close to me” was the only misfitting item with a mean squares value of 2.63. Finally, after item 24 was also dropped, all other items were found to have acceptable Infit mean squares values (under 1.4 mean square units).

The new person reliability and separation indices from the calibrations were .85 and 2.36, respectively. The new item reliability and separation indices were .80 and 2.00, respectively. Though these indices were lower from the original STSS analysis, this was expected due to the loss of information from the collapsing of categories and dropping of items. More importantly than this reduction of reliability and separation in items and persons is that the collapsing of categories into a more empirically logical order allowed for the item and person estimates to be taken literally.

The new item estimate mean from this scale calibration was 0.00 (.41), with a new person estimate mean of -.04 (.75). These results show (as was shown in the original STSS analysis) that this scale is a very well targeted scale. Additionally, the calibrated scale standard deviations for the mean estimates indicated that the variability of item estimates and person estimates were better matched than with the original STSS analysis. Finally, the response category diagnostics from the collapsing of categories and dropping of misfitting items are shown in Table 14. As in the original analysis, the observed average values and fit values were still within the acceptable range. Additionally, with the collapsing of two categories, the structure measure values were transformed into a logical order, indicating that the threshold probabilities increase stepwise. The structure measure values also were separated by an acceptable value of one after the data calibrations. The better rating category diagnostics were also confirmed by the category probability curves shown in Figure 11, which demonstrates that each category now has a modal peak for a portion of the construct. The person estimates attained from the analysis after collapsing of the two categories and the dropping of three items were used in the final ANOVA and ANCOVA analyses.

Calibrated Measures for the Beck Depression Inventory II

Due to the poor means square fit value of response category three of the BDI-II, it was collapsed into response category two. As a result, the new person separation index of 2.24 and reliability index of .83 indicated an increase in separation and reliability from before the category collapse. Additionally, the separation and reliability indices for the items increased as well (1.88 and .78, respectively). Finally, after collapsing category three, none of the items had misfitting mean square Infit values any longer (over 1.4). These beneficial increases in the reliability and fit indices indicate that the collapsing of category three caused the data to better fit the Rasch measurement expected model.

The item estimates mean from the analysis following the collapse of category three was .00 (.63) and the new person mean was -1.33 (1.35). Though the separation between item and person estimates means is not as severe as from the results of the analysis before category collapse, the means still indicate that the BDI-II is a poorly targeted scale for this sample even with the collapse of category three. The response category diagnostics are shown in Table 15. After the collapse of category three, the structure measure values were separated by one, which showed large improvement from the original structure measure separations. This indicated that the response categories and items were performing more in line with the Rasch model's expectations after the collapse of category three. Finally, the better rating category diagnostics were confirmed by the category probability curves shown in Figure 12 which demonstrates that each category has a modal peak for a portion of the construct. The person estimates attained from the analysis after collapsing category three were used in the final ANOVA and ANCOVA analyses.

Analyses with Rasch Measurement Model Calibrated Data

Correlations. The person estimates from the Rasch model measurement analysis of the calibrated STSS and BDI-II were used in all the final analyses. The correlation between the calibrated BDI-II and calibrated STSS scores was $r = .556$ ($p < .001$).

Relationships between report of a friend, report of abuse, and birthplace. A chi-square test of independence indicated a relationship between having a friend and the experience of abuse, χ^2 (2, N = 51) = 12.113, p = .002, $\varphi = .487$, such that those who reported having a friend were more likely to be women who

were not abused, and those who reported not having a friend were more likely to be women who reported abuse. The counts for each of these groups are shown in Figure 13.

A chi-square test of independence also indicated a relationship between having a friend and immigrant status, χ^2 (2, N = 53) = 7.51, p = .023, $\varphi = .376$, such that those women that reported not having a friend to talk to were more likely to be immigrants from India. The counts for each of these groups are shown in Figure 14. Finally, a chi-square test of independence indicated that there was no relationship between the experience of abuse and immigrant status, χ^2 (4, N =51) = 6.78, p = .148, $\varphi = .365$. Figure 15 displays the counts for each group.

Predicting the Silencing the Self Scale scores. Because of the small sample size, and the resulting limited number of participants in separate cells, multiple predictors could not be entered into the same model. Three one-way ANOVAS were conducted to test the effects of friendship, employment status, and experiences of abuse on STSS scores.

The results indicated a main effect of having at least one friend on STSS scores F(1, 51) = 19.135, $p < .001$, $\eta_p^2 = .273$, such that those women who reported having a friend to share their troubles with had lower STSS scores. The analysis of variance indicated that 25.90% of the variance in STSS was explained by the predictor of having a friend.

An ANOVA was conducted with employment status (employed or unemployed) to test whether employment, which puts women into contact with others within the workplace, can predict STSS scores. No main effect for employment was found, though the results indicate a trend to significance such that women who were employed (M = -.25, SD = .93) had lower STSS scores than women who were not employed (M = .19, SD = .88), F(1, 49) = 2.92 , $p = .094$, $\eta_p^2 = .056$.

A main effect of abuse on STSS scores was also found F(2, 51) = 13.441, $p < .001$, $\eta_p^2 = .359$. Tukey's HSD test indicated that those who had experienced verbal abuse, and those who had experienced both verbal and physical abuse, had higher STSS scores than those who had not experienced any abuse ($p < .05$). STSS scores for those who had experienced verbal abuse were not found to be different from those who had experienced both emotional and physical abuse. The analysis of variance indicated that 33.20% of the variance

in STSS was explained by the predictor of abuse experience. Means and standard deviations for STSS scores for all groups can be found in Table 16.

Predicting Beck Depression Inventory II scores. Three one-way ANOVAS were conducted to test the effects of friendship, employment status, and experiences of abuse on BDI-II scores.

The results indicated a main effect of having a friend on BDI-II scores $F(1, 51) = 9.113$, $p = .004$, $\eta_p^2 = .152$, such that those women who reported having a friend to share their troubles with had lower BDI-II scores. The analysis of variance indicated that 13.50% of the variance in BDI-II was explained by the predictor of having a friend.

No main effect for whether a woman was employed (M = -1.68, SD = 1.60) or unemployed (M = -1.49, SD = 1.77) was found for BDI scores, $F(1, 49) = .158$, $p = .693$, $\eta_p^2 = .003$.

A main effect of abuse was also found for BDI-II scores $F(2, 51) = 18.354$, $p < .001$, $\eta_p^2 = .359$. Tukey's HSD test indicated that those who had experienced verbal abuse, and those who had experienced both verbal and physical abuse, had higher BDI-II scores than those who had not experienced any abuse ($p < .05$). BDI-II scores for those who had experienced verbal abuse were not found to be different from those who had experienced both emotional and physical abuse. The analysis of variance indicated that 41.00% of the variance in BDI-II scores was explained by the predictor of abuse experience. Means and standard deviations for all groups can be found in Table 17.

Predicting Beck Depression Inventory II scores with the Silencing the Self Scale scores as a covariate. Finally, because silencing the self is a theory for the way in which women may develop depression, it was also of interest to see if social support and experience of abuse were significant predictors of BDI-II scores when controlling for STSS scores. Two one-way ANCOVAS were conducted to test the effects of friendship and experiences of abuse on BDI-II scores while entering in STSS scores as a covariate.

When STSS scores were entered as a covariate to reported friendship, STSS scores were found to significantly predict BDI-II scores $F(1, 51) = 12.79$, $p = .001$, $\eta_p^2 = .204$, and there was no main effect of having a friend on BDI-II scores $F(1, 51) = .977$, $p = .328$, $\eta_p^2 = .019$. This analysis indicates that most of the variability in BDI-II scores that the report of having a friend predicts overlaps with the variability in BDI-II scores that the STSS scores are able to predict. The analysis of variance indicated that 29.70% of the variance in

BDI-II scores was explained by this model, explaining 16.20% more variability than when friendship was entered alone as a predictor for BDI-II scores.

When STSS scores were entered as a covariate with reported abuse, STSS scores were found to be just under significance for a predictor of BDI-II scores $F(1, 51) = 3.866$, $p = .055$, $\eta_p^2 = .076$, and there was a main effect of abuse on BDI-II scores $F(1, 51) = 7.458$, $p = .002$, $\eta_p^2 = .241$. Again, Tukey's HSD test indicated that those who had experienced verbal abuse, and those who had experienced both verbal and physical abuse, had higher BDI-II scores than those who had not experienced any abuse ($p < .05$). BDI-II scores for those who had experienced verbal abuse were not found to be different from those who had experienced both emotional and physical abuse. The experience of abuse was found to predict depression as assessed by the BDI-II beyond what the STSS predicted. This model was found to predict 44.30% of the variation in BDI-II scores, explaining 3.30% more variability than when the experience of abuse was entered as a predictor alone.

Tests of Differential Item Functioning. In order to test for differential item functioning in the STSS due to immigration or abuse experience, the Infit mean squares values associated with the STSS person ability measure were tested. Two one-way ANOVAS were conducted to investigate the effect of immigration and experiences of abuse on STSS fit values. These results indicated no main effect of immigration, $F(2, 50) = .067$, $p = .935$, $\eta_p^2 = .03$, and no main effect of experience of abuse, $F(2, 48) = .286$, $p = .753$, $\eta_p^2 = 012$. The non-significant results indicate that the scales were not answered with significantly different amounts of error between groups. Means and standard deviations can be found in Table 18.

In order to test for differential item functioning in the BDI-II, the Infit mean squares values associated with each BDI-II person ability measure were also tested. Two one-way ANOVAS were conducted to investigate the effect of immigration and experiences of abuse on BDI-II fit values. These results showed no main effect of immigration, $F(2, 50) = .241$, $p = .423$, $\eta_p^2 = 034$, and no main effect of experience of abuse, $F(2, 46) = .455$, $p = .637$, $\eta_p^2 = .019$. Means and standard deviations can be found in Table 19.

Qualitative Results

The quantitative analysis alone shows the utility of the STSS for this population. It was in the qualitative portion of the focus groups, however, that the deep resonance of this scale with this group of women became manifestly clear. During multiple sessions women spontaneously remarked how the STSS got to the

heart of what they had suffered for many years, in a way that few had previously appreciated. In some groups, there were women who even burst into tears because of how the STSS questions probed issues at the core of their lived experiences.

Why then did the STSS resonate so well with this population, and did it capture a form of suffering related to or distinct from depression? Only the qualitative data from the focus groups is able to offer insight to these questions. The four Silencing the Self Scale subscales and the three depression questions were coded for, and other meta-categories that emerged were entrapment, inequality, standards and expectations, and negative cycles.

In the following sections, quotes from the women are provided to add to the most complete picture for each theme that emerged. These quotes are reproduced verbatim with regards to syntax and grammar to give the most honest representation of the women's experiences. Additionally, any boldface is the emphasis of the author.

Silencing the self reveals the social inequalities that cause women to be vulnerable to depression. This underlying theory was validated in the focus groups by the number of times and different forms of inequality that were discussed when speaking about the scale.

Inequality. While coding the focus group transcripts, the most prevalent inequality that emerged was the overall inequality between men and women. The second most common inequality that presented itself was between women that married into a family and women born into it. The third most common inequality can theoretically be characterized as another form of inequality between men and women, the inequality between the births of a girl or boy baby. This particular inequality was placed in its own category due to the many times this theme was brought up and spontaneously discussed in the focus groups. The final inequality that emerged was the inequality between newly immigrated Punjabi men and women and first generation Punjabi men and women. These inequality themes can be found in Table 20.

Men vs. women. The inequality between men and women was the most evident inequality theme throughout the focus group content, and women described that they had been raised to accept this inequality from a young age. Many women also mentioned how upset they used to be at the freedom that their brothers had at a young age when compared to their many restrictions. However, some women also mentioned that the

gender roles and expectations that were ingrained in them from a young age were fair expectations, such as that women are responsible for taking care of the domestic duties and men are responsible for working outside of the home. A similar point that was often raised was that women said that they did like taking care of their families and children and having the responsibility for that care. Rather, it was said that it is when women are burdened immensely more than the men with their housework, with no help, and no time alone to do things important for her as well, that it is unfair.

An additional topic that often came up in these discussions was the disruption and distortion of gender roles that happens after immigration:

> *One day, we were talking, me and my husband. So he said, um, like the home is uh take cares your responsibility, the child is your responsibility, blah blah blah. I think, okay. Everything is all my responsibility.* ***You want, I'm go outside, work and bring money. It my responsibility, home is my responsibility, child is my responsibility****. What is your responsibility? Just to go, um, go for work and come back, that's it? So, if I am told him, if you want I am going outside, and work, so then we are equal. If you want I'm stay home, just take care home and my child, it's okay. Then then, everything is my responsibility. If you want, I am going outside, then it not. We are equal, I don't like this. I you, we are come here in Canada. Where you think everybody, every lady is going outside and work, and you want it's me too. And you know, here, everybody is equal. It's not, it's not good. Equal's not good. It's a problem.* ***Because we're not equal.***

Many of the women echoed these concerns and said that they would be happy to do the housework if their husbands were the only one that worked outside of the home. Many of the women also explained that when they had to start working because money was scarce, their husbands did not absorb any of the house or child work because “a man doesn’t do those things,” nor did their husbands let them control any of the money. Additionally, a lot of the women acknowledged that there needs to be a shift in gender roles and expectations when immigrating to a new country for these reasons.

The second topic that emerged when the women discussed inequality between men and women was around blame and infidelity. There were many stories of the women’s husbands or friends’ husbands cheating on the wife and everyone turning a blind eye. Some of the women said that their families and in-law families

said that this infidelity from men was to be expected. More alarming were the accounts of the families blaming the woman for the husband's infidelity. Some of the women said that their families (usually in-law families) would say that if she had been a good wife then the husband would not of been unfaithful. Women also discussed the community's tendency to blame the woman and assume that she is being unfaithful if she is seen out anywhere alone. Some of the women told stories of their families receiving phone calls from concerned community members asking if "she had a boyfriend" when they saw her out without her family. Finally, and most importantly, women mentioned that the ultimate discrepancy between men and women for infidelity was the fact that a woman, if she is unfaithful, can be in very real danger of being harmed or killed.

Women vs. in-law women. The second most common inequality theme to emerge was the inequality between women who marry into their husband's families and the women who are part of the married women's in-law families. Most participants agreed that they had a lower standing in their families than their mother-in-law and sister-in-law. They said that especially during the first few years of joining the family, they had to listen to whatever their mother and sister in-laws said, and were not allowed to speak back to them or make any requests of their own. Moreover, many of the women spoke about how their husbands would listen to their mothers and sisters over their own wives. The women also discussed how their husbands treat their mothers and sisters with much more respect, and the hypocrisy of the times when their husbands had gotten mad over the fact that their sisters' husbands were abusing them, even if they themselves were abusing their own wives. When asked the reason for this inequality, many of the women said that it came down to bloodline and loyalty:

> *Yeah but I don't understand, why they are so protective of their mothers and their sisters. They are respected. So, I don't, that's the confusing.*
>
> *Is it because they've lived with them? They're more loyal to their own, to their mother and sisters, because they haven't lived with you as long, right? So they're not loyal to you.*
>
> *No but, see it's all about respecting women.*
>
> *Uhh, I think it's more my blood and, you're not.*
>
> ***You're nothing because you don't have anything to do with- your blood doesn't match ours.***
>
> *You know it's funny how it changes too. They'll say oh you're my daughter and we'll take*

care of you this way and. But that bloodline still, still gets in the way.

Girl child vs. boy child. Another common inequality observed was when women spoke about being pregnant and the pressures to have a baby boy. Some women spoke about being physically and emotionally abused by their husbands and mother-in-laws until they had a boy. Other women said that the abuse lessened for a bit after having baby boy, but continued again soon after:

> *And then, you know, and then you get pregnant. You know, if you don't get pregnant it's a problem. And when you do get pregnant it's a problem because then they have to have a baby boy. Like if you don't-* ***I was depressed when I was pregnant, because, because, my husband told me, if I'm going to have a girl- you're done! I'm going to leave you!*** *This is, it's true! I mean this is what I went through, and and and obviously my son was distressed.*
>
> *Even though you had two boys! You still had trouble?*
>
> *Yeah well, when I didn't know what I was going to have.* ***Right, I'm pregnant with my first child. And he said if you're not going to give me a baby boy, you're done with me. That's it, you're out the door. So all those nine months you're depressed, and you're thinking, oh my god, what's going to happen.*** *Praying to god, you know, that please, please, I should have- and you know then it's that what it is.* ***And second time, it's the same thing****. So it's the mentality, and he was born and raised here. So it's not just that, you know, you have to be not educated. It's all this mentality. Like this is, this is, how he used to think. So what are you supposed to do?* ***So you get two boys, but still he's still the same. Nothing changed.***

Women universally said that only they, not the men, are blamed if they cannot have children, or if they only give birth to daughters. Women also said that their extended families openly show more affection and preference for their sons over their daughters. Finally, many women told stories of attending baby blessing ceremonies at the temple and seeing parents and families cry over the fact that they had a girl and not a boy. Women said that they had seen even mothers cry for this.

Immigrant vs. non-immigrant. The final inequality theme that emerged from the focus groups was the inequality between new immigrants and first-generation Punjabi community members. People from both sides of this divide acknowledged that the two groups rarely interact. Immigrant women said that the immigrant

group tends to be a lot more economically disadvantaged than the first-generation group, and that the cultural differences of the old country creates issues and prejudice:

> *Yeah.* ***Very, very hard for them, a new environment and everything, and I don't think there's enough resources for, especially new comers because they're, you don't know what to expect, and there's a language barrier****.*
>
> *Right, and the, and the one thing, um, one thing more. I think something we all know, in Indian community, they don't put deodorant on and all this stuff, they stinks right, and sometimes peoples make laugh of them, when you go to the work, right. But it, didn't happen to me, but I know, people talk in the- I think so, when they come here they should give all the training about how to keep yourself right? Yeah they should give some housekeepings information. You know how you -*
>
> *Just how, yeah, just grooming, cause things are different here, right, and when they come here they don't know.* ***And there's nobody here standing at the airport saying okay by the way, when you come in this is how you adjust, and there's just a culture shock.***
>
> *And you know, in India, we put oil in our hair right? And you know, nobody, if you put oil in and you go in the class or the work, they make laughs, yeah. So housekeeping things, they should have some special classes like we have, uh, English classes, they should have something like that too.*

Interestingly, some first-generation participants expressed these prejudices and disdain in the focus groups.

Silencing the Self subscales. Overall, in coding for mentions of each of the four subscales in the focus group transcripts, the Silencing the Self subscale was mentioned most often, followed by the Externalized Self Perception scale, the Divided Self Scale, and finally the Care as Self Sacrifice scale. Throughout the discussion of each of these scales, four dominant levels of social environment were commonly referenced: the husband, the extended family (mostly in reference to the mother-in-law), the community at large, and the culture. As revealed in the focus group content, most women either were living or had lived for sometime in an extended family network (with their husband's and husband's parents, brothers, and their brother's families). For all of the scales, except for the Care as Self Sacrifice scale, the in-laws or extended family was listed as the largest influence (mentioned with the most frequency). Additionally, in general for each of the subscales except for the

Care as Self Sacrifice, the smaller levels of the social environment were mentioned with the greatest frequency and the larger levels of the social environment were mentioned with the least frequency. The specifics for the Care as Self Sacrifice subscale will be discussed later on. The themes for each of the subscales can be found in Table 21.

Silencing the Self subscale. The most pervasive of all the subscales in the focus group content was the Silencing the Self subscale, where the woman self-silences to avoid conflict. The three most common themes found when coding for this subscale were, from most frequently mentioned to least frequently mentioned: extended family, partners, and influences outside of the home. Self-silencing around the extended family, and in particular, mother-in-laws, was the most commonly mentioned domain, and the primary reason for this type of silencing was to "keep the peace." The majority of the women that discussed this issue mentioned that it was much more prudent to be silent than to have trouble directed at you for speaking out. The second most common reason given for silencing around the extended family was because speaking back to one's in-law parents is a form of the utmost disrespect. Many of the women mentioned that this tenet of respect was ingrained in them from a very young age, and most of them disagreed with this external expectation. Instead, the drive to avoid committing this disrespect was framed more as a drive to avoid the ramifications of this type of disrespect. Women frequently mentioned what the consequences would have been if they had spoken up, as shown in the following quote:

> *That's what I feel that one time, my brother-in-law went to pick me [up], my mother-in-law told me, oh you don't go stay in brother in law's house. But I could have answered her, your daughter is staying in brother in law house, and she's not married, I'm a married girl! It's just my husband is not here, I can spend anyway I want to go! I cannot speak,* ***I speak a word more, I'll be kicked out of the house.***
>
> ***Yeah you're the daughter-in-law, so it's better shut your mouth.*** *So that's how.*
>
> *You take a lot, right? You keep silent right? That's the worse.*
>
> ***Punjabi ladies all will be silent. Keep your mouth shut****, yeah.*
>
> ***Don't say anything, servants and daughter-in-laws have to keep their mouth shut.***

This quote also demonstrates the different standards that apply to women that marry into a family and women

that are born into a family. This was also addressed under the inequalities section.

The second most prevalent area of self-silencing voiced by the women was around their partners. The most commonly given reason for this was that if they were to speak to their partners about an issue, the mother-in-law would find out. Many women spoke about experiences where the husband would have to choose between their own mothers and wives in these circumstances, and would often pick their mothers because they had known them much longer. Additionally, as shown in the following excerpts, women who did speak out would be charged with trying to "break up the family:"

> *But you know the thing is that when anything goes wrong in the house- suppose you have a bad experience and somebody doesn't treat you properly- you have to keep your mouth shut because if you tell your husband about it, he won't trust you. Not only he won't trust you, the next thing is that, uh, you're trying to break up the family. So you're stuck in the middle of it. No way out.*

The second most reported reason for self-silencing around husbands was due to fear of abusive retaliation. Women mentioned that the best way to avoid physical and emotional retaliation from husbands was by "keeping the peace" by staying silent.

Finally, the third most common area for which the women self-silenced was for cultural traditions of privacy. Women often voiced the phrase "have to keep it in the home" to encapsulate the culturally mandated tradition of not spreading family business. As will be expounded on later in the analyses, women explained that much of this fear of sharing outside the home is also due to the gossip that ensues when community members find out about family troubles:

> *That's exactly it,* ***you can't say anything because you don't know what they going to say, who they going to say to, and what they going to do, and so you're suffering quietly****.* ***Whatever is going on in the home and you have no say in anything****. You know, you do something, you're bad, you don't do anything, you're bad.* ***You are the bad one all the time.*** *You know, and I have seen it over and over and over in our community. And I honestly, I'm at a point in my life, I would like to see some changing. They come from India, they have same mentality, and they're living in this country, and they don't want to change at all. You know, like we have to have some common place. We cannot just bring all that mentality and live in this country and, uh, be Indians. We have to make some changes. We have to give a little bit of free- they*

want the wives to go to work. They go to work, bring money, and they take the check. ***Wives are not allowed to spend the money the way they want to. They can't do the things they want to do for the children. They can't do things, uh, for themselves****, to make themselves look good, or feel good.* ***You know, a woman cannot go to a movie, or go to a restaurant alone, just to have good time. You do, and then ohhh something is wrong with her, she's running around.***

Externalized Self Perception subscale. The second most commonly coded subscale in the focus groups was the Externalized Self Perception subscale, where the woman judges herself negatively based on external standards. The most common area for which these self-judgments arose was in relation to the in-law family, in particular, the mother-in-law. Many of the women expressed that the in-law family always tells them when they are doing badly, never tells them when they do a good job, and that these judgments coming from others are often internalized:

No. you're not going to get any, oh yeah, you've done a good job, or you've done this for me, right? I mean you get it from your children maybe once in a while, because or you might even get it from your husband. ***But most of the time, extended family, they just don't, they expect a lot more out of you. And you can't give it, and then you try and keep on giving it****. That was my situation. I tried giving too much, and* ***I just could not meet up to the standards****.*

Another woman echoed this sentiment saying "they don't respect you until suddenly one day, you don't respect yourself."

The second most voiced area for self-judgments were those coming from the members of their community. Women mentioned that in the eyes of the community, only the woman is the "bad one." Women recounted stories where the way in which they would dress, when they would leave their houses, and with whom they would talk with was guided by what they thought the community would think. They said that this was because of how awful it feels to be judged by any community group, and to be labeled as "bad." The women said that these labels from the community were also internalized over time. Many women told stories of the ways in which the community would give them this label for a variety of other behaviors:

You know there is so much, just so much I need to say. Because you know, ***the community shuns you if you try to do something about it. They shun the woman not the man, you are the bad one****. You know I*

left, I, um, experienced the community shunning me. I was abused….If you can't have children, uh, it's the woman not the man. You know, the man could be the reason but it's never his fault. Um, (sighs) ***everyone blames the woman****.*

The final area mentioned for negative self-judgments was in relation to Punjabi culture as a whole. Women spoke about how whenever they deviated from what they had learned from a very young age made a good woman, they would feel bad because of the moral judgments that were attached to those deviations. These "good woman" values were said to be learned from the parents, the temple, and traditions. These judgments presented themselves from a very young age in a variety of avenues, including religion, as one woman described:

We believe so much of, this is our kismuth (destiny)… all those things ***are strong, like our core values that we were brought up with****, we think that, we just accept it****. Like as good women, we just accept it, and we think this is what my life is going to be like*** *for the next, I don't know, how many years. You* ***forget about your own needs, you don't, your needs don't matter anymore,*** *so that probably like, and you just adjust yourself to what's happening around you.*

This excerpt also shows how Care as Self Sacrifice is also engrained from a young age through cultural beliefs about the "good" Punjabi woman.

Divided Self subscale. The Divided Self subscale represents when a woman presents a compliant outer-self while having a resentful and angry inner-self. It was most often coded in reference to the way that the women felt they have to act inside the extended family home. Many women said that they had been a different person for up to the last fifty years because of living with their extended families. They said that they had to act, speak, and even dress as their extended families expected:

They're not checked, they're never wrong. So when you speak, your tone has to be right, grammar has to be right. So if I remain sane very long when you're living in that situation, if you say something, like, like, there's too much control? If you say something like, no no, I don't want that, oh my god! That's the wrong tone! Don't say that! ***So it's not possible to, you know, carry on, live like that. And people live like that for years. They expect perfection. And you do it, but you get angry and go mad.***

The second most coded theme was a divided-self due to the way many of the women feel they have to

act according to cultural standards. These standards had often been ingrained in the women from a young age, and the act of adhering to them was often voiced as having to pretend to be someone else. These standards were also voiced as those expected for a "good woman." The most common standards mentioned were to get married early, be the peacekeepers, as well as focus on husbands, extended family, and children. Finally, the third most common theme that arose for the Divided Self subscale was women having to be a different person in order to keep silent. Many of the women explained that having to keep silent inside and outside of their own homes causes them to feel a constant anger for having to be a woman that cannot speak. The other most commonly mentioned reactions to this divided self were rebelliousness, resentment when they become older, and despair as one woman mentioned:

> *But uh, uh, most times, we don't even realize, like I said**, I mean I didn't realize for a long time**. **Sometimes it starts off just a little bit**, Like uh, **you're unhappy, and you're just existing**. You do everything that needs to be done at home, you do everything with everybody**, but there is no cushi (happy) inside, you know, you're just doing it, right? You are doing it because, you have been told to do certain things because you don't even realize, okay, you have to exist a certain way, to exist a certain way, you become that person that they want you to be. You can't be you.***

Often times the requirement to be a different person was said to cause the women "to forget who they were."

Care as Self Sacrifice subscale. The least coded for scale was the Care as Self Sacrifice subscale, where the woman has to show care by putting her needs last within relationships. Women referenced the acts of putting the needs of others before their own mostly as culturally expected reasons that they had learned from a young age. This cultural expectations were described to be what makes a "good" woman. This is a reverse trend from the other subscales, in which other smaller levels of the social environment, such as family, were mentioned as the primary influences. Expectations for self-sacrifice from the in-law family was the second most commonly given reason. The final reason that arose was for the husband and children's needs. The women described this latter theme as an internal standard, as well as a standard due to external pressures. The references to cultural and in-law expectations, however, were all phrased as external pressures and standards, as explained during one focus group:

> ***Totally ingrained in our mind.***

Especially with in-law families.

You always have to think about them first*. We don't make our dinner, and we feed first. We have to feed them first. Then we eat, right?*

And they expect it.

I think ***it's expected*** *even, even, though I'm born and raised here and I remember growing up here and watching my mom.* ***Because it's ingrained especially in young girls****, um, um, minds, that when you grow up, you know first thing, you know bring the chai (tea).*

Additionally, mentions of the Care as Self Sacrifice subscale were also often paired with the phrase "the woman kills herself." This phrase was commonly used to represent both the mental suffering as well as the physical suffering the woman goes through in doing so much hard work for others.

Depression. Silencing the self theory conceptualizes that depression is related to social inequalities and oppression that can manifest also as a loss of self (Jack & Dill, 1992). Because of this underlying theory, explicit references to 1) "loss of self" and 2) depression, in relation to the four subscales were also coded for.

The most frequent associations between a thematic representation of one of the four subscales and an explicit reference to "loss of self" were with the Care as Self Sacrifice subscale, followed by the Silencing the Self subscale, and finally the Divided Self subscale. No references for "loss of self" were found with the Externalized Self Perception subscale.

With regards to depression and the STSS subscales, the most often referenced subscale was again Care as Self Sacrifice. Most commonly, the act of "killing oneself" with an inordinate number of duties and concern for other people's feelings was given as a cause for depression. The Silencing the Self subscale was the next most frequently mentioned subscale. In these instances, silencing itself was described as a cause of depression. The Divided Self was the third subscale most frequently associated with depression. The most frequently given reason was that having a divided self leads to an immense stress with having to be someone else, and it is this stress that causes depression. Finally, the Externalized Self Perception subscale was mentioned the least frequently. Interestingly, in a few of these instances, participants would say that the act of having depression also made them a "bad person" according to society. It appears that the very state of having depression also can instigate a negative external self-judgment.

The order of frequency in which the subscales of the STSS subscales were mentioned in reference to depression is exactly the same order as in reference to the loss of self. That is, the most coded subscale is CSS, followed by SS, DS, and ESP. Since the overall frequency of references to the subscales in the transcripts were in the order of SS, ESP, DS, and CSS, the order of the subscales in reference to loss of self and depression can not be attributed to the overall frequency of the subscales. The fact that the orders of the subscales are the same for explicit mentions of both "loss of self" and depression seems to give support for silencing the self theory as a theory for depression.

Causes of depression. For causes of depression (distinct from those directly related to STSS subscales), a woman living with an extended family with no power or control of her own was listed as the most common cause. Women repeatedly reported that this powerlessness is often also coupled with feelings of being left out:

> *Because what happens is, the girl, the woman, is deliberately left out. Everything. Not invited to join in the conversation. You know, you go late to the table, sometimes there's no food. You're the last one to eat. And they never think about that and you're the only one, you cooked it too.*

Additionally, women mentioned that having no friend or family support can also cause a woman to enter into a depression. Most commonly, women would say that these sources of support are important because women need someone with whom to talk. This finding is reciprocally reinforced by the theme of talking emerging as the number one reported treatment of depression. Stress from duties and family problems was the next most commonly listed cause for depression. Finally, abuse was the fourth most commonly referenced cause. Interestingly, emotional and verbal abuse were mentioned almost as often as physical abuse in reference to causes of depression.

Experiences of depression. When asked how depression is experienced, the most common theme that emerged was that many women did not know that they were depressed at first. Many said that though they knew something was wrong, they did not know what it was at the time. Often times this feeling of not knowing was compounded by family members telling the women that they had no reason to be feeling bad. Additionally, there were a few cases where the woman did not know that she had depression until she was admitted to a psychiatric clinic, because the depression had gotten so severe. The times in the focus groups when this theme emerged, a discussion would soon follow about the stigma of depression. Because of this, there were almost as

many references to the fact that many women also do not want to tell or admit that they have depression because it is a taboo subject as there were to the woman not knowing she had depression. As with other issues raised, women attributed this reluctance of acknowledging depression to a fear of "what will people say."

The next most common description in the way that the women experienced depression was by "entering a coma." Many described how this had happened to friends, or people with whom they had worked, while other women talked about how they had gone into a coma the first time that they became depressed:

When I had depression I just went into coma.

Yes, yes, that happened to my friend!

Yeah, I, uh, just went to sleep my family says and didn't wake up for two days. I don't remember it.

[Asked what caused the coma.]

Well you know it was lots of stress, you know. I remember I used to get so so stressed and, uh, would feel, uh-

Anxiety.

Yes, I would feel anxiety. And uh, my uh, here (points to chest), was heavy. And uh, I couldn't breathe, I couldn't take in breaths.

Additional ways in which the women said that they experienced depression (in order of frequency) was through acting out, not being able to sleep, rumination on stressors, feeling like they had a weight on their chests, and by seeing ghosts of their in-laws and parents. Acting out was described as a uncontrollable rage women would enter periodically when depressed where they would yell and scream hysterically at anyone close to them, especially their children. This way of experiencing depression may also explain why item 24 from the STSS "I rarely express anger at those close to me" was misfitting for this sample.

Treating Depression. When asked what can cure or aid in helping depression, the most frequent theme that emerged was talking, followed by taking time away from family, and then medications. Though most women emphasized that talking was the best way to combat depression, mixed results emerged for with whom women should talk. The individuals mentioned with the most frequency were counselors. In about 30% of these references, however, participants voiced that it does not help to see a "white" counselor. Women said that it was hard for them to trust someone that is from outside of their culture, and that it was exhausting to explain

traditions and values to their counselors. Most women agreed that the best scenario was to have a South Asian counselor that was not living in the same community or city as the women. A small number of women expressed fear of getting into trouble, or fear of getting their children taken away from them in references to counselors.

Friends were the next most mentioned individuals with whom to talk. A majority of these references stipulated that these friends must be good friends that can be trusted not to gossip to the community. For this reason, most women expressed that they talked to friends that are going through or have gone through similar circumstances as themselves. The women said that this allowed both people to trust each other because each had some situation about which they would not want the community gossiping. Many of the participants that were recent immigrants, however, said that making such friends is not possible because they do not have many opportunities to meet and make friends that they can trust outside of the home. Many of the women agreed that this was their experience as well during the first 10 or so years that they were new to the country. Finally, family members were the third most mentioned individuals with regards to talking. References to family, however, were overwhelmingly negative. Most women said that they could not trust anyone in their family to talk to about depression for fear that they will tell the other family members. Most women said that this was especially the case if an abusive relationship was causing their depression.

The second most mentioned cure for depression by women was taking time alone outside of the family. A small group of women in most focus groups mentioned that they take yoga classes that help them combat depression. Many of them explicitly said that they couldn't tell if it was the yoga or the time outside of the home. Many women also said that, though they don't get the opportunity to do so, they felt that trips alone or with friends for a weekend would alleviate a lot of their stress. Some women made the point that this time alone was important to them because it gave them a sense of "control" and "peace" that they did not have inside of the home.

The final theme that emerged as a cure for depression were medications. Many of the older women acknowledged that they were on anxiety medications, and many of the younger women said that their mothers and mother-in-laws were on them also. There were mixed feelings about whether medications are a good cure for depression. Many thought that though medication helps, other avenues of treatment, such as talking, would

be better alternatives. The majority of the women, even those that acknowledged taking medications, were very concerned about the addictive properties of antidepressants and antianxiety medications. Other women said that they did not want to take medications because then other family members and community members might find out that they have depression. The themes for the three depression questions can be found in Table 22.

Entrapment. Other themes that emerged during the coding process were reasons that forced women to stay in their abusive relationships or bad situations. These themes were related to obstacles that prevented women from reaching out and getting help for their situations. Because many of the participants had experienced domestic violence, and because domestic violence is such an important issue in the Punjabi communities these women were from, these themes were further examined. After a review of past domestic violence literature with similar themes, these domains were grouped under the larger umbrella category of entrapment (Brown, Harris, Hepworth, 1995). The most important entrapment themes that emerged from the focus group content were societal, abuse, circumstances unique to immigrants, and family bonds. Entrapment themes can be found in Table 23.

Societal entrapment. Societal entrapment emerged as the most common form of entrapment mentioned by the women, and was specifically manifested as a fear of community perceptions. This theme was also prevalent in previous sections. This form of entrapment was primarily based in a fear of negative gossip that was reported to be a far reaching and insidious type of gossip. Furthermore, many women mentioned that this type of gossip often put the women that are subjected to it in danger from their husbands or partners. Some women mentioned times that they had been out alone at a public place, and later in the day their husbands and extended families would hear about it from community members, putting the women in possible danger of misunderstanding and retaliation. The women expressed this sort of exposure and accountability through gossip as a persisting fear. Another form of entrapment around "what will people say" in the community was centered on the tendency for this type of community gossip to blame the woman. Many of the women told stories of being blamed for leaving or speaking out against her family by members of the community, even if the husband and extended family were doing abusive things to her. One woman spoke about the effects of both negative gossip and blame:

Yeah, and that's what's happens. And I think it's totally wrong. Why, you know, a man can do, they go

out of marriage relationships. They will go, you know, this is what I know and it's true, you know they go and pick up a girl, go to a motel, have sex with her, come home, and there is nothing wrong. And they give all those diseases to their wives, you know, and nothing wrong with that….But, ***if the woman goes to the shop, you know, why is she doing that? You know. Oh, there would be, there might be a boy somewhere. Boyfriend. You know, she's running around, she's doing this, she's doing that, and it's not true. Why can't they have a little bit of life themselves?***

The second most mentioned form of societal entrapment was the ostracism of the woman if she left her family, or if she spoke about her family problems outside of the house. Women recounted that when they left their husbands, even if it was due to his being abusive, soon after the dinner invites, phone calls, and public acknowledgements from community members would stop. Moreover, this harsh ostracism was described as extending to the children of the women as well. Many women also mentioned that though there were friends who did want to help and continue to talk to them, their husbands and families would not allow them to for fear of her bad influence spreading. One woman recounted her own experience with ostracism in which the negative effects of gossip can also be seen:

You know, you say something and you know like, people will say, oh ok, you can, you can tell me. I'm not going to tell anybody. Oh you can just- and you walk out of there, and it's all over town. Everybody knows it! The phone goes, this phone thing, you know, I think it's the worst thing that ever happened. ***And they phone each other, and by the time you go home, everybody in town knew, what you said.*** *And, every person, you know like,* ***one person is telling to the other, one thing more added to it, so the story gets really, really big by the time****. You know, that's what it is. And I grew up in that kind of environment. And, anything you did, you were judged… and when the problems started to get really worse in my home,* ***and I was shunned****. Totally,* ***nobody wanted to talk to me, nobody, and I was, I was the same person. They didn't want to look at me even. They would look at me in the store and they turned their head, so they won't have to say hi. You know, it went on for a year. And after one year, when we got back together, same people, same me, nothing had changed, and they were, oh! How are you? What's going on? You know****?*

Abuse. The second most prevalent form of entrapment mentioned in the focus groups was abuse.

Though there was a lot of physical abuse mentioned, many women explicitly mentioned the severe effects of mental and emotional abuse as well:

> *I actually know a woman. She, I work with her.* ***She went to coma actually, just because of depression…She was in coma for 6 months****. She was so dep- she was in depression****, she would not tell anyone, she suffer a lot from her in laws and husband. And again thinking what others, what others what others would tell her. And they just found her sleep****. She did not show to work, that's all they found out. She's just in her sleep, she just went to sleep. Coma. For six months she was in a coma****. Now she is separated and all, but it was the mental and verbal abuse. That's how much you know it can affect.***

Though much of the literature views abuse as a form of entrapment, entrapment references that kept women in abusive situations were also coded. The most commonly mentioned situations were due to the husband's consumption of alcohol, the in-law's knowledge of the abuse, and failed attempts for help. When many of the women spoke about their husbands' alcohol abuse problems, they often mentioned that drinking was their husbands' way of dealing with depression. Many of the women said that an abusive episode would often happen after their husbands had too much to drink. Many of the women also said that their in-laws turned a blind eye when they had knowledge of their sons and brothers abusing the wives. A minority of women told stories of their in-laws encouraging the abuse, and a few women told stories of their in-laws actually being the ones to physically abuse them a well. Finally, many of the women gave accounts of asking for help with regards to their husband's abuse, only to be rejected. Often women would reach out to family members for help, but no one would "want to get involved." One woman's experience demonstrates all three of the most common forms of entrapment found for abuse:

> *The whole family, you know* ***my husband, like he was drinking****. So I thought, the mothers cannot stand, this is what my feelings were, if the mother will see the son drinking, you know, they will feel hurt. So I sent for her, come here. She comes, and then I came from work, what I see,* ***she is sitting in the middle, three four guys, with her son, they are drinking! And I said, doesn't that bother you, that he's drinking? She says, oh everybody drinks here.*** *You know, that's what she said to me. And I was really, you know, doesn't matter how angry you are, and you want to hit them, you can't do that. You*

> *have to just, take it all in. And you know, it's really hard, when you're angry and you want to hit somebody, and you feel like, you know, this is the end of my life. And my condition was, before I got married, that I didn't want to get married to a guy who drank or smoked. But, he came here, and he started doing everything.* ***So in front of his mother he hit me. And she told him to hit me. And I had a huge black eye, that I was telling you before. So the parents, kind of, encourage all these things.***

Many of the women also spoke about friends or family members that they knew were being physically abused by their husbands, and said that they wanted to help but were stopped by their own families and husbands because they would say that by getting involved they were "inviting trouble into their own families."

Circumstances of immigration. Forms of entrapment specific to immigrant circumstances were also frequently mentioned. In order of frequency, themes that arose were: material and language restraints specific to Canada, fear of deportation, and lack of social support. Material restraints that were mentioned by the women included the extended families and husbands not allowing the women to have a driver's license or money. Women told stories of their extended families taking their passports upon immigrating and joining the family, so they could not travel. Additionally, women said that they were not allowed to go to school or learn English at first to keep them from being able to "run off." Women mentioned the power that their husbands and extended families had over them was also due to the immigration process. Because many of the women immigrated to marry their husbands, they talked of living in fear of deportation. They said that their husbands would threaten them with divorce and the ensuing deportation if they did not abide by the family rules, and also told them that they would have to leave their children as well. Finally, the women said that one of the most severe forms of entrapment that they faced due to immigration was the isolation. Upon coming to Canada, most of the women did not know anyone outside of their husbands and extended families. The women said that even when talking to their mothers and fathers, or their "old families," that some of their in-laws would listen and monitor the phone calls. One woman recounted her experience:

> *Some peoples' problems, you know, we came from India.* ***And, some families not in, not trust on her.*** *When I am coming from India,* ***my father-in-law not trust****. He thought, you know, my dad is in Toronto, I said I am coming first Toronto for one week and- but he thought, no, no!* ***He talk with my mother-in-law, 'she's come and no live there, she run away with other boy's son!'*** *Now I live*

> *separate, three year I live with them,* ***and they don't trust on me****. Even I have no driving license because I am not allowed to go outside. No work. They thought I quickly get pregnant, I have a child then I settle there.* *Now I am, maybe three and half year****, I have no license because I have no independent, I have no free. Yeah, they don't trust on us! They thought we are just here, and we are just waiting for something and we run away. I don't know why they are thinking that.***

Family-based. The last form of entrapment mentioned by the women centered on family reasons. In fact, as mentioned in the last woman's story, getting newly immigrant women pregnant was a way that some of the women said their extended families could be sure that they would stay. Many women also told stories of staying in their abusive relationships or bad living situations for their children. As mentioned in societal entrapment, often times the ostracism of the woman from the community for leaving her husband extends to the children. Most women said that they would rather suffer the abuse than let their children suffer.

The second most common reference towards family entrapment was due to the ideas of family values or family honor. Women mentioned the negative impact of a broken family, especially on the children, but they also mentioned the shame and stigma of ending a marriage. Additionally, women also spoke about how breaking a marriage would dishonor their own fathers and immediate families. One woman described the powerful influence of wanting to keep a family together:

> ***And you suffer, quietly. Because, if you, if you go out to get some help or something, then, still you are bad.*** *That you have gone to get some help. So what are you supposed to do? It's the guys that their thinking has to be changed. You know, it's not us.* ***We don't want to break the family, we don't want to break the kids in our lives. You know, we want them to have all the best in their lives****. But, what about us? What about our feelings, you know, we kill it.* ***So have to we, if we kill ourselves, then we can live in personal life. Otherwise we can break our families****.*

Finally, women referenced more active ways of family entrapment, such as the husband and the family withholding money from the woman.

Negative Cycles. Finally, two negative cycles were identified while coding the transcripts. One cycle that emerged was the ways in which women bring women down. The second cycle that emerged was the negative effects of children seeing what their parents do.

Women bring women down. The mostly widely discussed subject for the women bring women down theme was how women spread negative gossip about other women. Many of the women attributed this to an aspect of the culture in communities, where gossiping is a way in which women bond. Additionally, women said that they thought that the spread of particularly vicious gossip was due to jealousy and because "some families build themselves up on tearing others down." Finally, a minority of women said that a trend that they have observed is when abused daughter-in-laws become abusive mothers-in-laws.

Children see, children do. The most commonly mentioned theme for the negative effects that parents have on children was about money. Many women spoke about the constant race of immigrant families to prove that they have more money than other families. Often, this was said to show in the houses families live in, the cars that they drive, and in other material objects. Many women called this "keeping up with the Joneses" and said that their husbands would compete with their brothers and brother in-laws by often taking out loans and living out of their means to stay in competition. Women said that their children learn form this behavior, and additionally feel competition and peer pressure in their schools. Some women said that to earn money, their children had dropped out of school and turned to crime and selling drugs.

Another negative cycle mothers identified was the effects of seeing physical and emotional abuse on their children. Some women said that their daughters were very reluctant to get into relationships themselves, and some said that their daughters have planned to stay unmarried. Participants blamed themselves and the frequent abuse that they suffered as reasons for this. Other women said that their daughters had found "bad men" and entered unhealthy relationships, and also attributed this to their daughters seeing their own abuse. Finally, women said that their sons "acted out" by getting into fights, dropping out of school, and getting involved in crime due to seeing the abuse in their homes.

Discussion

For there are many great deeds done in the small struggles of life. There is a determined though unseen bravery that defends itself foot by foot in the darkness against the fatal invasions of necessity and dishonesty. Noble and mysterious triumphs that no eye sees and no fame rewards, and no flourish of triumph salutes. Life, misfortunes, isolation, abandonment, poverty, are battlefields that have their heroes, sometimes greater than the illustrious heroes" (Les Miserables, p. 678).

One of the principles in psychometrics is the foundation of valid and true interval measurement scales for human constructs, so that researchers can effectively compare results from one study to another (Bond & Fox, 2007). The formation of these comparable scales is especially important for cultural studies so that researchers can utilize both theory and practice to dialectically arrive at insights across cultures. Rasch measurement analysis is one avenue through which the establishment of these comparable measures can be achieved. The information that Rasch measurement analysis provided for both of the utilized scales in this study, such as the response category diagnostics and misfitting item information, would not have been evident through conventional analysis techniques (Trimble & Vaughn, in press). Additionally, the information from the qualitative components helped to validate as well as provide immeasurable depth and context to the quantitative results. Along with the relationships with social service providers in the communities, this more complete picture has formed the backbone for understanding how the insights of this research can be actualized and incorporated into ongoing efforts to address the suffering of women like those who participated in this study.

In terms of the quantitative metrics, the Silencing the Self Scale (STSS) was found to be a well-targeted scale for assessing levels of self-silencing, and was shown to perform optimally for this sample after collapsing two response categories and dropping items 1, 22, and 24. Qualitative analysis of focus group data found that women identified the extended family as the most frequent domain in which they experienced Silencing the Self, Externalized Self Perception, and the Divided Self. For Care as Self Sacrifice (where the woman puts the needs of others before her own to exemplify care), however, culturally enforced reasons emerged as the largest domain in which women felt that they had to exhibit such behavior. Finally, the absence of having a friend to speak to about troubles, as well as reports of verbal and physical abuse, were found to be significant predictors for higher STSS scores. Women who reported not having a friend to talk to were more likely to be immigrants than those women that reported abuse. Conversely, the Beck Depression Inventory II (BDI-II) was found through Rasch measurement analysis to lack sensitivity for assessing depression in this sample, and the qualitative data identified several ways in which the women said that they experience depression distinct from the symptoms captured by the BDI-II. Finally, the qualitative data identified several domains of entrapment, for which societal entrapment was the most common.

The Silencing the Self Scale

The STSS identifies how the social context becomes internalized into the self through inequality and oppression and can, among other things, lead to depression (Jack, 1991). Indeed, the inequality between men and women was the most apparent theme throughout the focus group content, and may be one reason that the STSS was so resonant with the participants. That is, the scale was well developed to tap into women's experiences with depression. Repeatedly, the emphases in focus group discussions circled from inequality, to entrapment, to violence. Because social context may shape one's thoughts, behaviors, and feelings of self-worth (Jack & Ali, 2010), the STSS also effectively highlighted the culturally enforced reasons that women are silenced. Though sources of suffering are inextricable from the larger social inequality milieu, the most commonly mentioned tangible sources were unstable family dynamics and abuse.

Domestic abuse and family dynamics. Discussions of male privilege pervaded throughout all of the focus groups, and explanations of male privilege were intertwined in statements of gender roles and expectations for women. Past studies with Punjabi men and women have found male privilege to specifically translate into male-centered justifications for verbal, physical, and sexual abuse (Abraham, 2000). Most telling of these justifications is the way in which marital intimacy and male privilege have been found to intersect, where men have the power to define the sexual act. Because of this power many men do not consider it sexual abuse if he forces the wife to have sex with him (Abraham, 2000). While there has been much work investigating the connections between male privilege, entitlement, power, and sexual abuse, the discussions of male privilege in the current study shed light on the complex dynamics between privilege and its support in the extended family.

One of the most compelling themes that emerged from the study overall was that though the man often is the perpetrator of violence and emotional abuse, he is often excused and supported in his actions by the extended family. This critical sentiment exposes the idea that to effectively combat issues such as domestic violence, the larger familial context needs to be addressed. An even more commonly reported reason for the husband's abusive behaviors from the qualitative data was attributed to the husband's drinking of alcohol. Most women described alcohol abuse with Punjabi men as a very common and serious problem in the community. Other studies have echoed this observation and have found the drinking of alcohol to be associated with Punjabi

masculinity (Sandhu, 2009). Studies have also noted that Punjabi men may drink more as immigrants in host countries because of acculturation stress, or because it is symbolic of modernity (Sandhu, 2009; Agic, 2004). Research has so far identified several avenues through which Punjabi men may abuse alcohol, but whatever the reasons, Punjabi men have been found to be at higher risk of alcohol abuse than any other South Asian group (Agic, 2004).

While many of the social services for Punjabi communities address and acknowledge the impact of alcohol abuse on the abusive behaviors of men, there is much less literature on the impact of in-law knowledge on men's abusive behaviors. Women from the study described situations in which their extended family would condone or excuse their husband's drinking behaviors. Though in-law knowledge of abusive behaviors and alcohol abuse in husbands can be linked to a larger context of male privilege, where the privilege may allow a space for these behaviors, a more direct discussion of the role of the extended family in this context is needed. These findings of the direct impact that extended family members have on marital abuse and drinking behaviors provide a tangible point of intervention through family and group counseling, rather than individual and couples therapy. One limitation of the current study was in not assessing whether or not the participants lived in extended family households. Future studies with STSS and immigrant families may use the identification of living within an extended family network to more specifically examine its role with STSS scores, husbands' drinking behaviors, and husbands' abusive behaviors for better developed interventions.

One unpredicted finding from the current study was the impact verbal abuse has on STSS scores. There were no women who reported experiencing physical abuse without verbal abuse, and women who had only experienced verbal abuse were as likely to have higher STSS scores than those who had experienced both verbal and physical abuse. Emotional abuse has been found in past research with Punjabi women to be coupled often with physical abuse (Gill, 2004). It has also been found to humiliate, lower self-esteem, and further entrap women in their abusive situations (Gill, 2004). What these findings suggest is that addressing verbal and emotional abuse may be as important as addressing physical abuse for women's wellbeing.

Entrapment. Within the context of entrapment, the study identified societal entrapment to be the most common form of entrapment mentioned, while societal ostracism was found to be the most common sub-domain. This form of severe ostracism exists in many other cultures and can be conceptualized as the ultimate

form of stigmatization; researchers have called it social death with regards to the stigmatization of mental illness (Yang, Kleinman, Link & Phelan, 2007). The current study observed that social death might occur in these communities as a response to the woman leaving her husband and family. Perhaps more damaging was the fact that this social death was also described to apply to the children of the woman. Interestingly, while social death has been conceptualized to be as a result of mental illness in other cultures, it seems to be a cause of mental illness for women in this community, whether from the stress of being ostracized or from the stress of staying in an abusive situation for fear of ostracism. Within these communities, the forces that lead to, or lead from, social death form cyclical associations with entrapment with regards to abuse, family dynamics, and community perceptions.

Intersections with domestic violence. Research has shown that domestic violence is associated with many different contexts including culture, marginalization, and gender (Sokoloff & Dupont, 2005). In this community, it seems that for domestic violence to be effectively combated, service providers must also address the ostracism and extended family issues that women face, as well as addressing the abusive behaviors directly with men. Programs that can pull women out of their isolating circumstances can help to connect women with a personal friend, which was shown in this study to be associated with lower STSS scores. Through the same programs, services may also combat the many forms of immigrant specific entrapment that were identified in the study, such as isolation resulting from knowing only the extended family members in a new country.

To prevent abuse and entrapment, the expectations of the communities and extended families for women need also to be addressed, as participants identified that when a woman does not adhere to these prescribed standards, abuse or strife in the extended family can occur. It is important to note that traditional gender roles, traditional expectations of women, and extended family structures are not the sources of the problems experienced by women in these communities. There is nothing intrinsically wrong with these roles and expectations, as they alone do not lead to suffering of the women in this community. In fact, to blindly label these cultural traditions as such only serves to further marginalize and problematize Punjabi culture. Rather, it is the exploitation of these gender roles and extended family standards through unequal power dynamics in relationships that is the source of suffering and therefore what needs to be addressed.

Lateral Oppression. An additional domain of societal entrapment found from the study was in reference to negative gossip and the idea of "what will people say" in the community, which participants identified as being a female perpetuated phenomenon. The female perpetuated gossip is a representation of lateral oppression (also known as lateral violence, horizontal violence, and horizontal oppression), which includes gossip that has the end result of shaming and blaming others (Wingard, 2010). Lateral oppression is defined to be the harming and undermining of others within an oppressed group, and these actions are thought to be a result of marginalization (Collins, 2010). In this way, some women from the Punjabi culture can be conceptualized to bring fellow women down to the same standards to which they are held hostage.

The most obvious and emotionally distressing form of lateral oppression, as heard in the focus groups, was that of a mother-in-law towards her daughter-in-law. Woman after woman spoke of the suffering that they had had to endure at the hands of her mother-in-law. Women said that their mother-in-laws would belittle, demean, and abuse them even physically if they did something that was wrong or not up to the standards of the family, community, or culture. Providing further support for a lateral oppression framework were participants' explanations for why they thought that their mother-in-laws acted in these ways towards them. Many of the women said simply that their mother-in-laws had to act like that because it was they way in which they were incorporated into their own families as well.

More enlightening perhaps were the instances when women recounted their horrible histories with their own mother-in-laws, but when describing their daughter-in-laws, tended to use negative and disparaging remarks. When asked about these occurrences in follow-up group discussions, many of the women said that they had learned from their own experiences and were much more accepting of their daughter-in-laws than they had experienced. Others, however, acknowledged that they still expected their daughter-in-laws to adhere to traditional standards and expectations, even if this was not what the daughter-in-law wanted. Women also mentioned that they struggle with the fact that their sons help with the cooking and the cleaning, which should be the daughter-in-law's role. Finally, many women also negatively commented on the fact that "modern girls these days wear the pants."

What these comments indicate is that the divide between cultural standards and traditions that make a "good woman," and those that oppress, overlap and shift within the Punjabi cultural context. Furthermore, male

privilege and gender expectations also seem to play an integral part in the development of lateral violence through the construction of standards and expectations for women. Future work should focus on delineating between these beliefs and expectations of women, with women, to assess how to curb the negative impact women can potentially have on each other through gossip in a community.

A benefit of conceptualizing themes from the study within the lateral oppression framework is that it can also apply at many levels. For example, lateral oppression can apply to the inequality between immigrants and non-immigrants that was voiced by participants in the study. Work with American-Indian communities has framed lateral violence as the expression of "anti colonial rage working itself out in an expression for hate for one another" (Maracle, p. 11). In this way, perhaps lateral violence in the Punjabi community can be conceptualized as an expression of Western influence, racism, and gender violence into the oppression of one another. Several community-wide conferences open to the public currently take place in the areas in which the current study was conducted to raise domestic violence awareness. The findings from this study related to lateral oppression indicate that these community conferences may also benefit from directly addressing issues relating to lateral oppression within the Punjabi community, within families, and with women in the community, by encouraging harmony and respect.

Social Support. As discussed previously, the reporting of having a friend with whom to discuss problems by participants was highly predictive of lower STSS scores in this study and highlighted the benefits of having even just one person in a social support system. Though the current study did not have the power to test a mediation model, the fact that the significance of reported social support on BDI-II scores disappeared when controlling for STSS scores as a covariate is enlightening. These results imply that social support and its protective relationship to depression that has been identified in many studies may be due to its role with silencing the self. Also interesting was that employment, which could put women in close contact with people outside of their extended family, did not predict STSS scores though the association did trend toward statistical significance. If there is in fact an association between employment and self silencing that this study was not able to detect, it would be important to determine if this reflects employment promoting social support, less abusive family dynamics permitting women to work, or some other reason.

Social support as a protective factor against depression has been identified in studies within Western individualistic contexts, as well as within culturally collectivistic contexts (Brown, Harris & Hepworth, 1995; Rodrigues, Patel, Jaswal & de Souza, 2003). This study adds to a growing body of evidence pointing towards social support as a protectant against depression for immigrant communities (Noh & Kasper, 2003). For example, Ali and Toner (2001) found that when comparing women living in the Caribbean with immigrant Caribbean women in Canada, the immigrant women scored significantly higher on the STSS and BDI-II. The authors also found that social support systems were associated with lower self-silencing and depression in both groups. These support networks may be even more important within the immigrant context, especially for isolated recent immigrants as the current study identified. Because of this, and the reasons aforementioned, increasing social support though programs aimed at pulling immigrant women out of isolation is a promising area for service providers to powerfully intervene.

The findings, along with the robust evidence for social support and its protective relationship with depression in many other studies, lend more credibility to the idea that depression in women is characterized by disconnectedness (Jack & Ali, 2010). The fact that having a confiding intimate or non-intimate relationship is highly protective against depression leads to additional questions; such as, does talking to a counselor have the same effects as talking to a friend? Pursuing questions such as this will elucidate what are the critical components in these social support systems that protect against depression. What is also interesting is that while STSS behaviors may be protective and necessary in abusive and dangerous relationships (Jack & Ali, 2010), it may also prevent the formation of social support networks by preventing the creation of healthy relationships with others. Future work may need to also investigate whether STSS behaviors in women reach across all relationships in the woman's life at the time, or whether the behaviors are specific only to problematic and dangerous relationships.

Silencing the Self, immigration, and culture. Use of STSS with this sample of women also serves to extend applications of silencing the self theory with the immigrant experience. Because the STSS is steeped in the social milieu, it can be effectively extended to an examination of how cultural context shapes self-silencing. In the current study, inequalities between Punjabi culture and the dominant Western culture were not commonly mentioned in the focus groups, and this absence is contrary to findings from other studies with immigrant

groups and the STSS. In a study conducted with Caribbean immigrant women in both Canada and America, several themes emerged based around the dominant non-Caribbean culture for both groups (Ali, 2010). Though the design of the focus groups was adapted from the study by Ali (2010), the women in the current study almost exclusively discussed issues with inequality within the Punjabi culture and community context. This finding gives evidence to the fact that Punjabi culture in these immigrant communities is well insulated, and has important implications associated with it.

Past work has found that Punjabi identity is critically developed as a result of immigration. Specifically, Punjabi identity in Canada has been found to be defined by what it is not, namely by not being westernized (Merali, 2009). Many of the women brought up this issue in the focus groups by saying that it is worse to be a child of immigrant parents, or to be married to a child of immigrant parents (first generation), because the family retains their values from back when they immigrated. The women said that while the families and parents in India modernize as a country, with some of the old traditions, expectations, and standards becoming antiquated, the immigrant-based families in Canada tend to retain a more static cultural identity because any modernization is viewed as a Western influence. Some of the women explained that many families based in Canada believe that a Punjabi girl raised in Canada (first generation) may be too non-traditional, and so many travel to India to find brides for their sons. These sentiments have been also been supported with past studies of Punjabi families in Canada, where to preserve cultural heritage and traditional systems, families of Canadian males find marriage partners from India (Merali, 2009). This set-up becomes particularity problematic when the bride is actually more non-traditional or modern than the extended family in India. This harsh clash in expectations and reality may lead to unstable and unsuccessful marriages, as the participants spoke about.

Women also mentioned that arranged marriages between Canadian men and Indian women now have moved away from matchmaking, and more towards sponsorship of connected family members. These arrangements invite the woman into unsuitable families, and place stressors of sponsorship debt, where the sponsor (husband) reminds the woman of the debt she owes to him and his family because they have had to cover for all of her basic needs (Kang, 2006). The issue of sponsorship debt was raised in some of the focus groups, and women said that while policies have changed as a result of attention brought to this issue, many of

the immigrant women are not aware of their rights. This lack of awareness of rights was a common theme, where immigrant women said that they didn't know about their rights surrounding property ownership, domestic violence, and their children. For the many forms of entrapment that emerged from this study, this lack of knowledge of rights applied to most domains. This lack of knowledge could be an effect of isolation and programs that effectively pull these women from their isolating circumstances need to also provide an avenue through which women can learn their rights in Canada.

The participants involved in the study are best understood from a collectivistic standpoint due to the great importance placed on harmonious family dynamics. Perhaps the additional stressors of having to please more individuals than just a partner may be a factor contributing to the high STSS scores for this group of women. A study by Jack, Pokharel, and Subba (2010) examined self-silencing in the collectivistic culture of Nepal with the question of whether silencing the self looks different from Western cultures. The authors found that Care as Self Sacrifice and Silencing the Self were integral in what it means to be a "good woman" in the Nepali culture, and that emphasis on harmony within the extended family was also important. Additionally, 35% of women participants referred to problems with in laws while 40% referred to problems with their husband. In the current study, in-law problems were an even more commonly cited than husbands, with issues with extended family references being the highest domain for three of the STSS subscales. Also similar to the current study (Silencing the Self was the third most mentioned domain for the references to the Divided Self), the Nepali study found Divided Self and Silencing the Self to be inextricably connected, and identified similar gender role emphasis and norms for what makes a "good woman."

These overlapping themes between the current study and the Nepali study raise questions for whether STSS looks similar across collectivistic cultures, especially in those cultures that emphasize extended family harmony. The current study also echoed the results from the Nepal study, where self-silencing was utilized as a survival strategy to avoid emotional, physical, and economic consequences from those of higher power within the family. Additional questions that follow from the similarity in findings from these two studies are whether silencing the self in all collectivistic cultures emphasizes family and an interdependent sense of self. Another question would be whether silencing the self in collectivistic cultures translates into higher relationship-based associations for the development of depression than in individualistic cultures. Finally, while the questions in

the STSS examine intimate partner relationships, would the same questions in reference to extended family dynamics be even more applicable to cultures where extended families are the norm?

While the STSS has been found to be very applicable with some collectivistic cultures, meanings behind the silencing may still look different from culture to culture. As mentioned, when examining the subscale data, extended family was found to be the number one domain in which women experienced Silencing the Self, Externalized Self Perception, and the Divided Self. The qualitative data for these subscales identified domains in order of frequency from a generally smaller community (extended family, husbands, children, etc.) to a larger one (community or culture). The domains for which participant exhibited Care as Self Sacrifice, however, were in the reverse trend. First culture was referenced most often, then extended family, and finally husband and children. Additionally, it should be pointed out that the majority of Care as Self Sacrifice items that were misfits were not longer misfits after two of the response categories were collapsed. As detailed in the results, the problematic response category was "*strongly agree*" where participants found it easier to endorse "*strongly agree*" for many of the items, even if their STSS scores were lower overall. This trend was especially apparent for the misfitting Care as Self Sacrifice items that were identified.

What these observations may mean when the quantitative and qualitative data are combined is that Care as Self-Sacrifice, as a construct, may be more culturally ingrained. Many women told stories of Care as Self Sacrifice being taught to them as integral for "good values" from a very young age. Furthermore, many women said that as a young child, they would have to do things like bring the food and make the tea for others, and that their brothers did not have to do the same. Perhaps then, the Care of Self Sacrifice items from the STSS reflect a more integral part of the culture, and do not fluctuate with intimate relationships in the same way that the other subscales do. While the distinction between culture and family is a false dichotomy, where family is a very real part of culture, the question that remains is what are the influences outside of family and extended family that may have caused women to list Punjabi culture as the most frequent area for Care as Self Sacrifice

The data from this study distinguish some reoccurring suggestions in ways to help women living in similar immigrant based communities, and the women in the study themselves voiced many of the suggestions. Because of the large emphasis on extended family, and the many instances of distress voiced by the women as a result of extended family dynamics, individual or even couples therapy will not address the root of the women's

suffering. Rather, several of the findings from the study show that family therapy would be a good alternative. This is something that many of the practitioners that were contacted with regards to the study are well aware of and acknowledge. However, many practitioners explained that the main obstacle for providing these services is a lack of funding for family therapy sessions. Many counselors said that the grants that support the services they provide are specified for individual therapy. The implication of this is that Western-based mental health assumptions, with regards to effective therapy in this case, are not best suited for use with this culture.

It is the hope that this research can provide empirically based findings that validate what the practitioners already know to aid in requests for properly focused services. Additionally, it is suggested that counselors and other service providers utilize the STSS as a way of initiating conversation with women, as this was found to be very effective in the study. Many women remarked that the scale tapped into very core experiences and brought them to the surface so that they could speak about things that they had previously not been able to before. In fact, two focus group sessions ended with the participants remarking that they felt like some of their depression had lifted because of the material they were able to discuss.

Depression

The core of silencing the self theory identifies close and healthy relationships as essential for a woman's wellbeing. Additionally, the theory frames social inequality and social expectations regarding gender as contributing to cognitive schemas about self in relationships to create a vulnerability to depression. In the current study, the STSS and BDI-II scores had a very strong correlation, which showed that the extent to which depression was assessed with the BDI-II was strongly associated with STSS scores. Though there was a very strong correlation, however, there was a limited range in depression scores, as shown with the poor targeting and variability of the levels of depression that items were able to assess made evident by Rasch measurement analysis. This poor targeting may be a main reason why participants on average were found to only have a mean level of “mild” depression as assessed by the BDI-II, while the majority of the women in focus groups self disclosed that they were severely depressed. As with the STSS, the qualitative data was examined to find reasons that might explain why the BDI-II was so inefficient at picking up depression in this sample. When asked how the women experienced depression, only one of the most frequently coded answers overlapped with the symptoms assessed in the BDI-II (trouble sleeping). Since the BDI-II is a symptomology based depression

assessment tool, it seems that it is assessing for the wrong symptoms in this population and may not pick up the most salient symptoms of depression.

In examining the most given responses to how depression is experienced, there was a blend of somatic (comas, amnesia), cognitive (rumination), and spiritual complaints (seeing ghosts). Additionally, one of the ways in which women said they experience depression, a weight on the chest, was described as both a physical and metaphorical weight that would obstruct breathing. This way of experiencing depression as described by the women most closely resembles a particular symptom has been identified in the past as a Punjabi culture-bound experience of depression, "sinking heart syndrome" (Krause, 1989). "Sinking heart syndrome" has been described as a combination of physical, emotional, and social pathologies that manifest as symptoms in the heart and chest. Though it is stressed as primarily somatic, when asked for further clarification, "sinking heart syndrome" also involves explanations involving the emotional and spiritual, and is voiced in response to both social and emotional distress.

Similar emerging themes in relation to the cultural ways in which to express depression have been echoed in several other studies examining the expression of depression. Other studies have found that symptoms are first voiced in what seems to be a purely somatic manner, but upon further description involve supernatural, social, and personal stress as well. For example, in Zimbabwe, depression has been found to present as headaches, fatigue, and with symptoms related to heart and head. However, when asked further, many patients will elaborate on cognitive and emotional manifestations as well (Patel et al., 2001). This trend of experiences of depression first being interpreted as somatic symptoms may be partly due to a breakdown of language. Cultural specific terminology for depression and anxiety has been found to have what seems to be a somatic meaning through pure translation, but in actuality holds dual somatic and emotional meanings in many cultures (Patel, Pereira, & Mann, 1998; Nations, Camino, & Walker, 1988; Reynolds & Swartz, 1993). These findings show that it is imperative for researchers and practitioners to not only be fluent in the strict translations of languages, but to also be fluent in the cultural specific interpretations and nuances. As mentioned, the current study could have never proceeded without key informants to crosscheck and give cultural backing for many observations. The connections to key informants, or community individuals that are intimately familiar with the cultural and local dynamics, were found to be essential for this type of cultural research.

The fact that the BDI-II was not successful at assessing many of the identified symptoms of depression in women from this sample may be due to its development based on Western assumptions of how distress is experienced and internalized. The findings from this study again stress the importance of translating Western-based assumptions of mental health and illness across to other cultures. The observation that the BDI-II did not assess high levels of depression in these women, yet a high level of depression was voiced during the focus group interviews, also corresponds with past findings of Punjabi men and women in Western countries. Studies have found that when Punjabi participants are assessed for depression, they are reported by practitioners to have low rates of depression in primary care settings, yet when assessed in ethnographic studies, they are found to have higher rates of depression than Western counterparts (Belliappa, 1991). When given a chance to describe distress, it seems that Punjabi rates of depression are as prevalent if not higher from Western populations (Bhuui, Bhugra, Goldberd, Sauer, Tylee, 2004; Patten et al., 2006).

One final area that must be mentioned as integral to the reporting of depression across culture is stigma. Stangor and Crandall (2000) identified stigma as a dynamic interactional component of a culture, and classified mental illness as engendering stigma through tangible threats and symbolic threats. According to the authors, these forms of stigma cause depressed individuals from cultures where mental illness is stigmatized to feel pressured to report only physical symptoms. This observation may also explain why many cultures do not possess a word to describe depression as an illness in their language (Ormel et al., 1994). Mentions of stigma in the current study were observed in reference to women not knowing that they had depression. Because the subject is still taboo in much of the community, women did not feel that they had space to talk about it. Stigma was also mentioned in reference to medications for depression and anxiety. Participants said that they were reluctant to go in to see professionals for their depression because the resulting medications they would be prescribed would be very observable labels for depression to community members. Community conferences that have been organized by social services in these communities have been effective in creating and continuing dialogue for domestic violence. Through the same approaches perhaps, dialogue for mental health and depression can also be achieved.

Though many symptoms of depression were identified by asking how women experience depression, it may be prudent to also include social indicators for depression in a well designed depression scale for this

population. A wide variety of social factors have been found to lead to higher depression, and the quantitative and qualitative findings in this study show that the STSS is a good representation of the social factors that may impact depression. It is the suggestion of the author that in the development of a culturally sensitive depression scale for Punjabi women a more interpersonal focus is necessary.

Ideally, for a good symptomology-based depression assessment, future work may have to endeavor to create a depression scale for this population from the ground up, much like the silencing the self was created from the narratives of depressed women (Jack & Dill, 1992). However, this study has validated silencing the self as an avenue through which depression develops in this culture. Furthermore, many of the women included in this study were on the margins of being fluent in English, and knowledge of English itself was found to be an immigrant specific isolating factor in the qualitative analyses. For this reason, a truly sensitive depression scale for this population must be developed in both Punjabi and English.

Conclusions

The current study found that many forms of inequality influence silencing the self, which was, in turn, intimately associated with depression. This resonance of the STSS scale with the women in this study was clearly seen in both the quantitative and qualitative findings. From this study, it is apparent that culture, structural forces, and immigration affect silencing the self, depression, and domestic violence, and that the women in this study were found to be on the margins of society, gender, and often times, within their own families.

It is also apparent from this study that the many complexities of culture, social structure, and immigration interact synergistically, and not additively, in the lives of these women. Social services should try to increase women's agency within this these cultural complexities to give her control while increasing harmony within family dynamics. One example of this would be to specifically target the inter- and intra-generational lateral oppression amongst women. Another would be to more aggressively address the issue of alcohol abuse by men through an understanding of the experiences and frustrations that engender such consumption as well as the family dynamics that permit it. While these approaches are not new ideas to service providers in the Punjabi communities, the empirical validation of this knowledge may help organizations to secure the funding needed to address these issues as the social, and not individual, problems that they are. Only

in doing so will services respect the number one goal and desire as voiced by the women: to avoid "breaking the family" while having a nurturing environment for their children and themselves.

The study highlighted that the mental health assumptions, assessment tools, and practices used in Western cultures cannot simply be applied within this culture. The use of Western mental health frameworks regarding depression decontextualizes depression to a degree to which it may be no longer analogous in this culture. Truly sensitive mental health practices for Punjabi women must respect the social, cultural, and familial contexts in which the women are embedded. To be truly effective, these practices must also encompass the marginalization, racism, fear, and powerlessness that immigrant Punjabi women face.

Often times, especially in Western psychology, depression is conceived to be an intra-psychic phenomenon. In this way, depression is thought to be experienced solely in the individual. The findings from the study, and from countless other studies, demonstrate that depression is not only related to context, but that social environment may often be the cause for depression. As a result, relationships, family dynamics, community politics, and culturally enforced standards and expectations are all levels that have to be addressed to combat individual suffering.

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Table 1

Descriptive Statistics for Scales and Subscales

Scale	Subscale	N	Minimum	Maximum	M	SD
STSS		55	44.00	143.00	94.33	23.80
	Externalized Self Perception	55	7.00	30.00	19.38	5.74
	Care as Self Sacrifice	55	14.00	41.00	28.05	6.33
	Silencing the Self	55	12.00	42.00	27.07	7.72
	Divided Self	55	7.00	35.00	19.82	7.23
BDI-II		55	0.00	49.00	13.05	13.05

Note. STSS = Silencing the Self Scale; BDI-II = Beck Depression Inventory II.

Table 2

Reliability Statistics for Scales

Scale	Subscale	N	Chronbach's Alpha
Silencing the Self Scale		48	.94
	Externalized Self Perception	52	.83
	Care as Self Sacrifice	55	.67
	Silencing the Self	53	.81
	Divided Self	52	.85
Beck Depression Inventory II		45	.94

Table 3

Care as Self Sacrifice Subscale Inter-Item Correlations

	1	3	4	9	10	11	12	22	29
1	-								
3	.32	-							
4	**-.09**	.37	-						
9	.01	.45	.32	-					
10	**-.14**	.22	.14	.28	-				
11	.35	.33	.36	.12	.18	-			
12	.05	.25	.22	.18	.50	.32	-		
22	**-.02**	.13	.45	.23	.32	**-.11**	.33	-	
29	**-.30**	**-.05**	.24	**-.06**	.52	.02	.19	.30	-

Note. Negative correlation values are in boldface.

Table 4

The Silencing the Self Subscale Correlations

	Externalized Self Perception	Care as Self Sacrifice	Silencing the Self	Divided Self
ESP	--	.66**	.68**	.71**
CSS		--	.64**	.60**
SS			--	.87**
DS				--

Note. **$p < .01$.

Table 5

Rasch Measurement Summary Item and Person Statistics for the Silencing the Self Scale

		Infit		Outfit			
	Estimate	MNSQ	STD	MNSQ	STD	Reliability	Separation
	Mean	(SD)	(SD)	(SD)	(SD)		
Item	0.00 (0.36)	1.01	-0.20	1.07	0.00	.86	2.50
		(0.36)	(2.00)	(0.64)	(2.40)		
Person	-0.01 (0.67)	1.08	-0.10	1.08	0.00	.91	3.09
		(0.52)	(1.60)	(0.46)	(1.50)		

Note. Estimate values are in logits. MNSQ = mean squares fit values; STD = t-standardized fit values.

Table 6

Rasch Measurement Item Estimates and Fit Statistics for the Silencing the Self Scale

			Infit		Outfit	
Item	Estimates	Error	MNSQ	STD	MNSQ	STD
1	**0.12**	**0.12**	**2.26**	**6.00**	**4.09**	**9.70**
2	-0.35	0.13	1.16	0.80	1.14	0.70
3	**-0.79**	**0.14**	**1.46**	**1.90**	**1.33**	**1.20**
4	0.43	0.12	0.97	-0.20	0.97	-0.10
5	0.19	0.12	0.96	-0.20	0.87	-0.70
6	-0.40	0.13	0.90	-0.60	0.84	-0.80
7	-0.21	0.12	1.11	0.60	1.05	0.20
8	0.28	0.12	0.65	-2.60	0.61	-2.40
9	-0.81	0.15	0.86	-0.70	0.90	-0.40
10	-0.41	0.13	0.56	-2.80	0.60	-2.30
11	**0.60**	**0.12**	**1.45**	**2.30**	**1.41**	**1.70**
12	**-1.60**	**0.12**	**1.40**	**2.10**	**1.38**	**1.80**
13	-0.04	0.12	0.91	-0.50	0.83	-0.90
14	-0.33	0.13	0.75	-1.51	0.77	1.12
15	**0.04**	**0.12**	**1.45**	**2.50**	**1.49**	**2.30**
16	-0.28	0.13	0.85	-0.90	0.87	-0.70
17	0.15	0.12	0.77	-1.60	0.75	1.50
18	-0.08	0.12	0.67	-2.20	0.63	2.20
19	0.24	0.12	0.65	-2.60	0.60	2.50
20	**0.44**	**0.12**	**1.46**	**2.50**	**1.74**	**3.00**
21	0.54	0.12	1.02	0.10	0.89	-0.50
22	**0.60**	**0.12**	**1.50**	**2.60**	**1.70**	**2.70**
23	0.09	0.12	0.70	-2.10	0.64	2.20
24	0.35	0.12	0.85	-1.00	1.37	1.70
25	0.29	0.12	1.07	0.50	1.00	0.00
26	-0.12	0.12	0.76	-1.60	0.71	1.70
27	-0.32	0.13	1.05	0.30	0.97	-0.10
28	-0.09	0.12	0.91	-0.60	0.84	-0.90
29	-0.06	0.12	1.01	0.10	1.10	0.50
30	0.02	0.12	0.71	-2.00	0.66	-2.00
31	0.07	0.12	0.52	-3.60	0.51	-3.10

Note. Estimate values are in logits. Poor fit items are in boldface. MNSQ = mean squares fit values; STD = t-standardized fit values.

Table 7

Rasch Measurement Response Category Diagnostics for the Silencing the Self Scale

Category Label	Observed Count (%)	Observed Average	Expected Average	Infit MNSQ	Outfit MNSQ	Structure Measure	S.E.
Strongly D	346 (20)	-0.70	-0.70	1.04	1.17	--	--
Somewhat D	292 (17)	-0.30	-0.34	0.93	0.84	-0.34	.07
Neither A nor D	253 (15)	-0.05	-0.04	1.04	1.05	-0.04	.06
Somewhat A	496 (29)	0.24	0.27	0.96	0.86	**-0.56***	.06
Strongly A	303 (18)	0.68	0.65	1.03	1.25	0.94	.07

Note. Unexpected structure measure value is in boldface. D = Disagree; A = Agree; MNSQ = mean squares fit values; S.E. = Standard Error.

Table 8

Rasch Measurement Summary Item and Person Statistics for the Care as Self Sacrifice Subscale

		Infit		Outfit			
	Estimate	MNSQ	STD	MNSQ	STD	Reliability	Separation
	Mean						
Item	0.00	0.99	-0.10	1.01	0.00	.93	3.53
	(0.47)	(0.27)	(1.60)	(0.46)	(1.50)		
Person	0.03	1.03	-0.20	1.01	-0.20	.64	1.35
	(0.58)	(0.53)	(1.30)	(0.53)	(1.20)		

Note. Estimate values are in logits. MNSQ = mean squares fit values; STD = t-standardized fit values.

Table 9

Rasch Measurement Item Estimates and Fit Statistics for the Care as Self Sacrifice Subscale

			Infit		Outfit	
Item	Measure	Error	MNSQ	STD	MNSQ	STD
1	**0.16**	**0.11**	**1.58**	**3.20**	**1.83**	**3.70**
3	-0.66	0.14	0.91	-0.50	0.82	-0.80
4	0.44	0.12	0.91	-0.60	0.86	-0.80
9	-0.68	0.14	0.69	-1.60	0.75	-1.10
10	-0.33	0.12	0.58	-2.80	0.68	-1.80
11	0.60	0.12	1.12	0.70	1.07	.030
12	-0.10	0.12	0.98	-0.10	0.90	-0.50
22	0.60	0.12	1.17	1.00	1.04	0.20
29	-0.01	0.11	0.94	-0.40	1.18	0.90

Note. Estimate values are in logits. Poor fit item is in boldface. MNSQ = mean squares fit values; STD = t-standardized fit values.

Table 10

Rasch Measurement Response Category Diagnostics for the Care as Self Sacrifice Subscale

Category Label	Observed Count (%)	Observed Average	Expected Average	Infit MNSQ	Outfit MNSQ	Structure Measure	S.E.
Strongly D	112 (23)	-0.68	-0.63	0.93	0.91	None	None
Somewhat D	64 (13)	-0.32	-0.35	0.75	0.53	0.07	.13
Neither A nor D	74 (15)	0.01	-0.05	1.10	1.24	-0.35	.12
Somewhat A	144 (29)	0.34	0.29	0.82	0.82	**-0.55***	.11
Strongly A	101 (20)	0.58	0.67	1.32	1.39	0.83	.13

Note. Unexpected structure measure value is in boldface. D = Disagree; A = Agree; MNSQ = mean squares fit values; S.E. = Standard Error.

Table 11

Rasch Measurement Summary Item and Person Statistics for the Beck Depression Inventory II

		Infit		Outfit			
	Estimate	MNSQ	STD	MNSQ	STD	Separation	Reliability
	Mean						
Item	0.00	1.02	-0.20	1.22 (1.34)	-0.10	1.50	.69
	(0.42)	(0.47)	(1.70)		(1.90)		
Person	-1.54	1.05	-0.10	1.22 (1.13)	0.00	2.18	.83
	(1.26)	(0.52)	(1.00)		(1.10)		

Note. Estimate values are in logits. MNSQ = mean squares fit values; STD = t-standardized fit values.

Table 12

Rasch Measurement Item Estimates and Fit Statistics for the Beck Depression Inventory II

			Infit		Outfit	
Item	Estimate	Error	MNSQ	ZSTD	MNSQ	ZSTD
1	-0.11	0.21	0.62	-2.00	0.56	1.60
2	**0.47**	**0.23**	**1.38**	**1.30**	**2.38**	**2.50**
3	-0.09	0.20	0.81	-0.90	0.58	-1.50
4	-0.35	0.20	0.69	-1.60	0.70	1.10
5	0.22	0.22	0.67	-1.60	0.55	1.50
6	-0.45	0.19	1.00	0.00	0.75	-0.90
7	0.48	0.23	0.80	-0.80	0.58	-1.20
8	-0.26	0.20	1.12	0.60	1.38	1.10
9	0.56	0.25	1.08	0.30	0.61	-1.00
10	**0.22**	**0.22**	**1.74**	**2.50**	**1.30**	**0.70**
11	-0.39	0.20	1.03	0.20	0.83	-0.60
12	-0.18	0.20	1.13	0.60	1.21	0.60
13	-0.54	0.19	0.54	-2.60	0.64	-1.50
14	**0.53**	**0.24**	**1.04**	**0.10**	**1.58**	**1.20**
15	-0.30	0.20	0.43	-3.40	0.39	-2.70
16	**-0.22**	**0.21**	**1.15**	**0.60**	**1.69**	**1.80**
17	-0.66	0.19	0.65	-2.00	0.78	-0.90
18	0.65	0.24	0.66	-1.50	0.43	-1.70
19	**0.71**	**0.25**	**2.60**	**4.10**	**6.79**	**5.90**
20	0.17	0.22	1.19	0.80	0.93	-0.20
21	-0.45	0.20	1.06	0.30	0.91	-0.30

Note. Estimate values are in logits. Poor fit items are in boldface. MNSQ = Mean squares fit values; STD = t-standardized fit values.

Table 13

Rasch Measurement Response Category Diagnostics for the Beck Depression Inventory II

Category Label	Observed Count (%)	Observed Average	Expected Average	Infit MNSQ	Outfit MNSQ	Structure Measure	S.E.

0	653 (59)	-2.18	-2.18	0.98	0.99	None	None
1	252 (23)	-1.12	-1.12	0.91	0.96	-0.69	.08
2	116 (10)	-0.11	-0.20	0.84	0.83	0.13	.10
3	78 (7)	0.37	0.47	1.15	**2.69**	0.55	.14

Note. Unacceptable fit value is in boldface. D = Disagree; A = Agree; MNSQ = mean squares fit values; S.E. = Standard Error.

Table 14

Rasch Measurement Response Category Diagnostics for the Collapsed Silencing the Self Scale

Category Label	Observed Average	Expected Average	Infit MNSQ	Outfit MNSQ	Structure Measure	S.E.
Strongly D	-0.92	-0.93	1.07	1.06	None	None
Neither A nor D	0.00	0.01	0.91	0.62	-0.57	.10
Strongly A	0.69	0.69	1.03	1.18	0.57	.10

Note. D = Disagree; A = Agree; MNSQ = mean squares fit values; S.E. = Standard Error.

Table 15

Rasch Measurement Response Category Diagnostics for the Collapsed Beck Depression Inventory II

Category Label	Observed Average	Expected Average	Infit MNSQ	Outfit MNSQ	Structure Measure	S.E.
0	-2.09	-2.09	1.00	1.02	None	None
1	-0.84	-0.80	1.00	1.04	-0.54	.08
2	0.32	0.29	0.97	1.03	0.54	.12

Note. MNSQ = mean squares fit values; S.E. = Standard Error.

Table 16

Rasch Calibrated Silencing the Self Scale Means for Reports of Friend and Experience of Abuse

Friend	Abuse	Place of Birth	Mean	SD	N
No	--	--	0.73	0.85	15
Yes	--	--	-0.31	0.76	38
Total	--	--	-0.02	0.91	53
--	No Abuse	--	-0.55	0.77	26
--	Verbal Abuse	--	0.45	0.29	11
--	Verbal and Physical Abuse	--	0.61	0.95	14
--	Total	--	-0.02	0.92	51
--	--	India			
--	--	Other			
--	--	Canada			
--	--	Total			

Note. Mean scores are in logits.

Table 17

Rasch Calibrated Beck Depression Inventory II Means for Reports of Friend and Experience of Abuse

Friend	Abuse	Place of Birth	Mean	SD	N
No	--	--	-0.56	1.32	15
Yes	--	--	-1.97	1.61	38
Total	--	--	-1.57	1.65	53
--	No Abuse	--	-2.57	1.39	26
--	Verbal Abuse	--	-0.89	1.09	11
--	Verbal and Physical Abuse	--	-0.16	1.15	14
--	Total	--	-1.55	1.65	51
--	--	India			
--	--	Other			
--	--	Canada			
--	--	Total			

Note. Mean scores are in logits.

Table 18

Rasch Calibrated Silencing the Self Scale Infit Means

Place of Birth	Abuse	Mean	SD	N
India	--	1.05	0.59	41
Other	--	1.04	0.50	9
Canada		1.14	0.23	5
Total	--	1.06	0.54	55
--	No Abuse	1.06	0.38	26
--	Verbal Abuse	0.95	0.19	11
--	Verbal and Physical Abuse	1.11	0.91	14
--	Total	1.05	0.55	51

Note. Mean scores are in unstandardized mean squares Infit fit statistic values.

Table 19

Rasch Calibrated Beck Depression Inventory II Infit Means

Place of Birth	Abuse	Mean	SD	N
India	--	1.10	0.59	39
Other	--	0.85	0.25	9
Canada		0.98	0.18	5
Total	--	1.05	0.52	53
--	No Abuse	1.10	0.66	24
--	Verbal Abuse	0.96	0.34	11
--	Verbal and Physical Abuse	0.97	0.23	14
--	Total	1.03	0.50	49

Note. Mean scores are in unstandardized mean squares Infit fit statistic values.

Table 20

Inductively Developed Thematic Categories for Inequality

Thematic Category	Key Ideas
Men v. Women	Freedom
	Distortion of Gender Roles after Immigration
	Blame and Infidelity
Women v. In-Law Women	Must be Subservient
	Bloodlines and Loyalty
	Husband's Hypocrisy
Girl Child v. Boy Child	Pressures to have Son
	Grandparents Love Grandson more than Granddaughters
	Parents Lament having Daughters
Immigrant v. Non-Immigrant	Immigrants more Economically Disadvantaged
	Immigrants don't know Western Cultural Norms

Note. Thematic categories and key ideas are listed in order of frequency.

Table 21

Inductively Developed Thematic Categories for Silencing the Self Subscales

Subscale	Thematic Category	Key Ideas
Silencing the Self	Extended Family	Mother-in-Laws, Respect, "Keep the Peace."
	Partners	Mother-in-Laws, Abuse, "Break up the Family," "Keep the Peace."
	Cultural/Community	Tradition, Privacy, "Keep it in the Home," Gossip.
Externalized Self Perception	In-Law Family	Mother-in-Laws, Tell Woman that she is Doing a Bad Job, Internalized.
	Community	Blame the Woman, Label her as "Bad," Internalized.
	Cultural	Idea of a "Good Woman."
Divided Self	Extended Family	Act and Speak as Expected.
	Cultural	Get Married Early, Be Caretaker, Be Peacekeeper.
	Keeping Silent	Be Someone Else to Keep Silent, Anger, Rebelliousness, Despair.
Care as Self Sacrifice	Cultural	Ingrained from childhood, For Parents, External Pressure.
	In-Law Family	Their Domestic Needs, Caretaker, External Pressure, "Woman Kills Herself."
	Husband and Children	Internal and External Pressure, "Woman Kills Herself."

Note. Subscales, thematic categories, and key ideas are listed in order of frequency.

Table 22

Inductively Developed Thematic Categories for Depression Questions

Category	Thematic Category	Key Ideas
Causes of Depression	Extended Family	No Control, Left Out.
	No one to Talk to	From Friends, From Family.
	Stress	Family Problems, Duties.
	Abuse	Physical, Verbal and Emotional.
Experience of Depression	Did Not Know	Did not Know What it Was, Taboo Subject.
	Coma	Described as Sleeping for Days or Months.
	Acting Out	Fighting With Children, Yelling and Screaming.
	Cannot Sleep	--
	Ruminations	About Stresses, About Duties, About Family Problems.
	Inability to Breath	Described as a Weight on Chest.
	Seeing Ghosts	Of Parents, Of In-Law Parents
Treating Depression	Talking	Mixed Results for Counselors, Good Friends, Cannot Trust Family
	Having Time Alone	Time Away From Family is Key, Yoga, "Control," "Peace"
	Medication	Older Women on Anti-Anxiety Medications, Other Treatments are Better, Concern for Addiction, Label for Depression

Note. Depression categories, thematic categories, and key ideas are listed in order of frequency. Coded causes of depression listed are references that could not be attributed to the Silencing the Self Scale subscales. Care as Self Sacrifice and Silencing the Self were both given as causes for depression more frequently than any of the listed causes.

Table 23

Inductively Developed Thematic Categories for Entrapment

Thematic Category	Key Ideas
Societal	Negative Gossip
	Blame the Woman
	Ostracism
Abuse	Physical Abuse
	Emotional and Verbal Abuse
	Husband's Alcohol Abuse
	In-Law Knowledge of the Abuse
	Failed Attempts for Help
Immigrant Circumstances	Material Restraints
	No English
	Fear of Deportation
	Isolation
Family-Based	Don't Want to "Break the Family"
	Family Honor

Note. Thematic categories and key ideas are listed in order of frequency.

Table 24

Inductively Developed Thematic Categories for Negative Cycles

Thematic Category	Key Ideas
Children See, Children Do	Money as Important
	Effects of Seeing Abuse
Women Bring Women Down	Gossip
	Daughter-in-Law to Mother-in-Law

Note. Thematic categories and key ideas are listed in order of frequency.

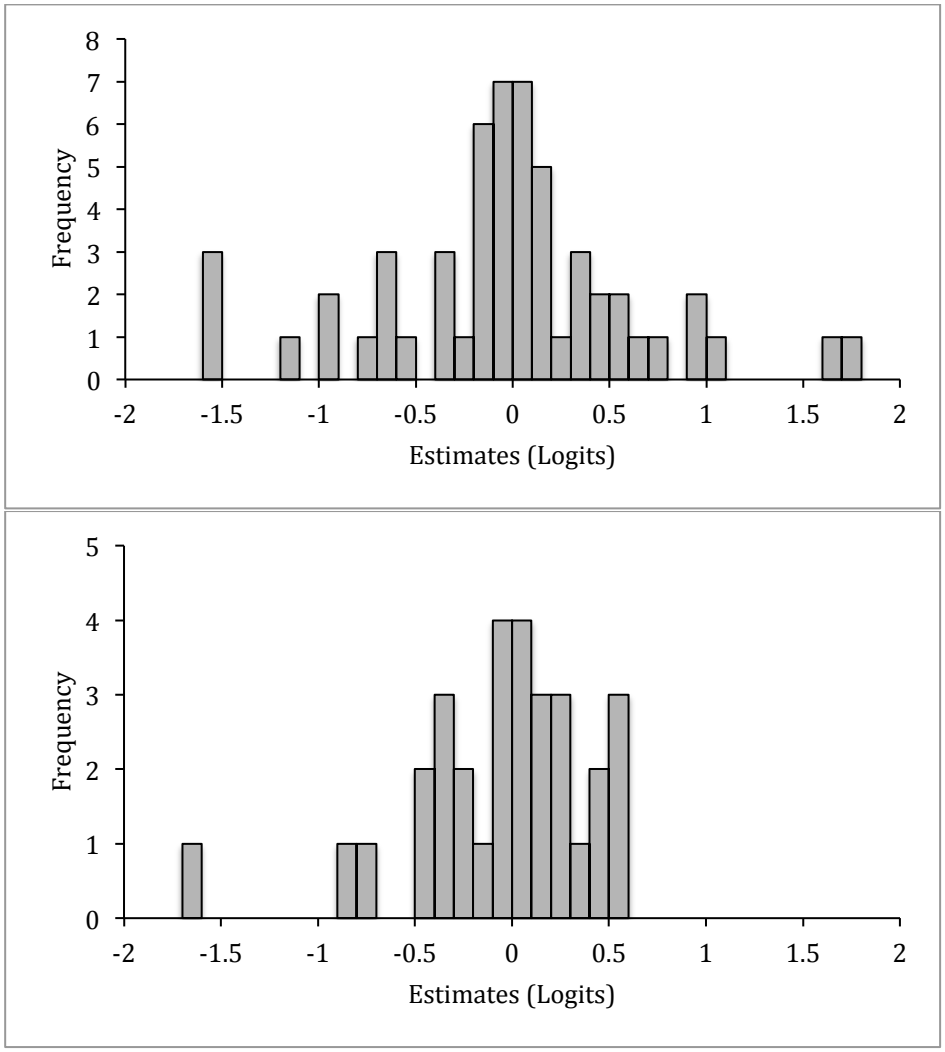

Figure 1. Frequency distributions of participant performances on the Silencing the Self Scale (top) and the Silencing the Self Scale item performances (bottom). Zero logits is the total item estimate mean. Item $N = 31$; Participant $N = 55$.

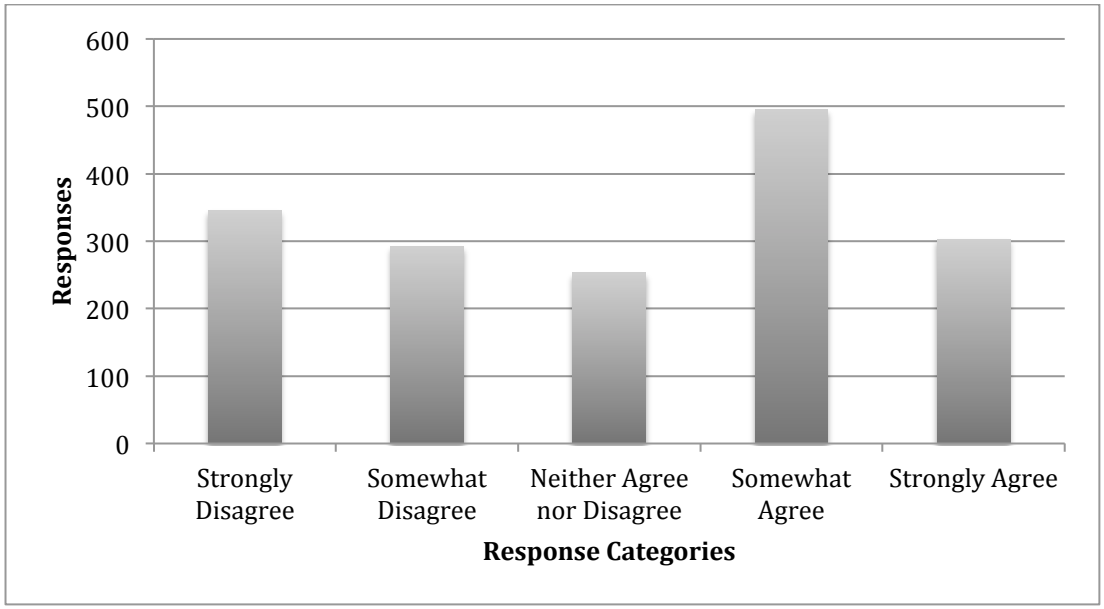

Figure 2. The Silencing the Self Scale response category distribution for 55 participants and 31 items.

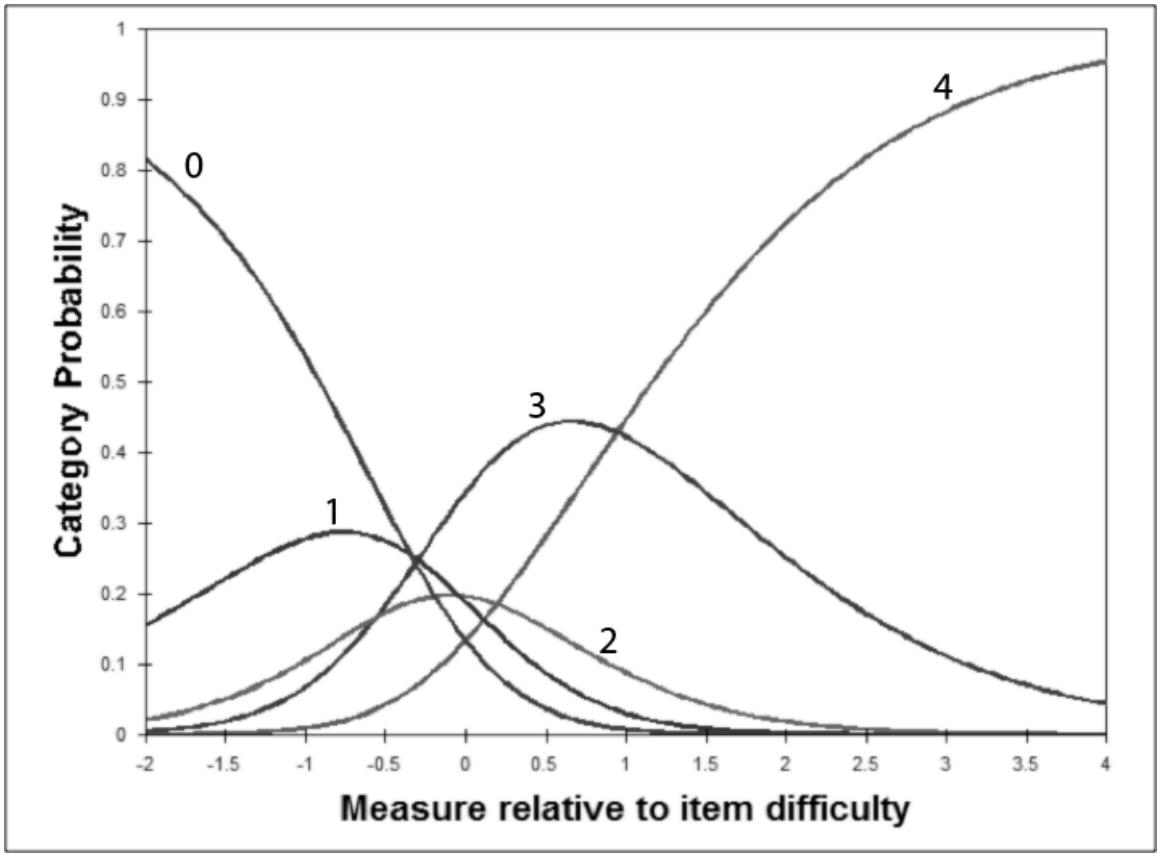

Figure 3. Response category probability curves for the Silencing the Self Scale. Y-axis indicates category probability, or the likelihood of endorsement. X-axis indicates the person estimate (measure) subtracted from item difficulty. Zero indicates response category *strongly disagree*; 1 indicates response category *somewhat disagree*; 2 indicates response category *neither agree nor disagree*; 3 indicates response category *somewhat agree*; 4 indicates response category *strongly agree*.

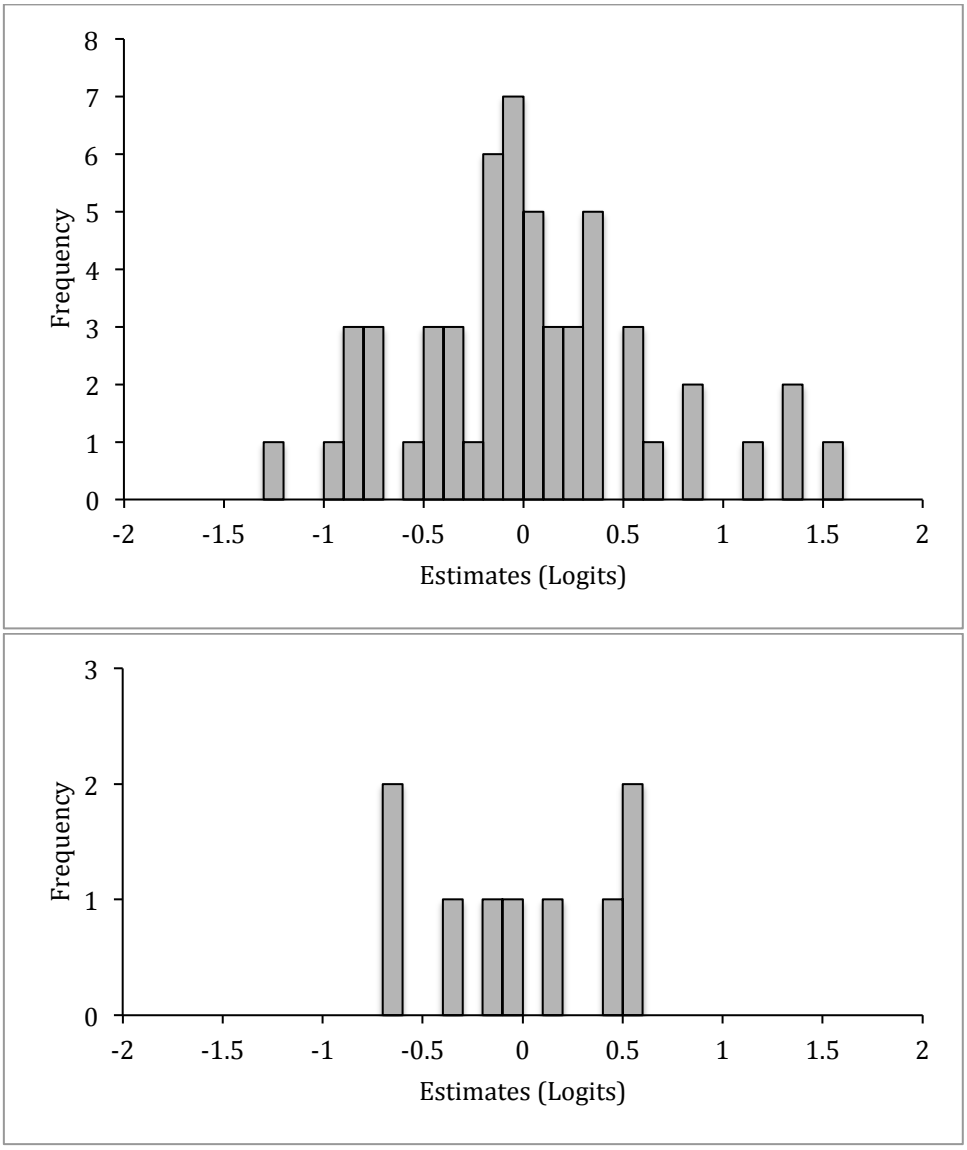

Figure 4. Frequency distributions of participant performances on the Care as Self Sacrifice subscale (top) and the Care as Self Sacrifice subscale item performances (bottom). Zero logits is the total item estimate mean. Item $N = 9$; Participant $N = 55$.

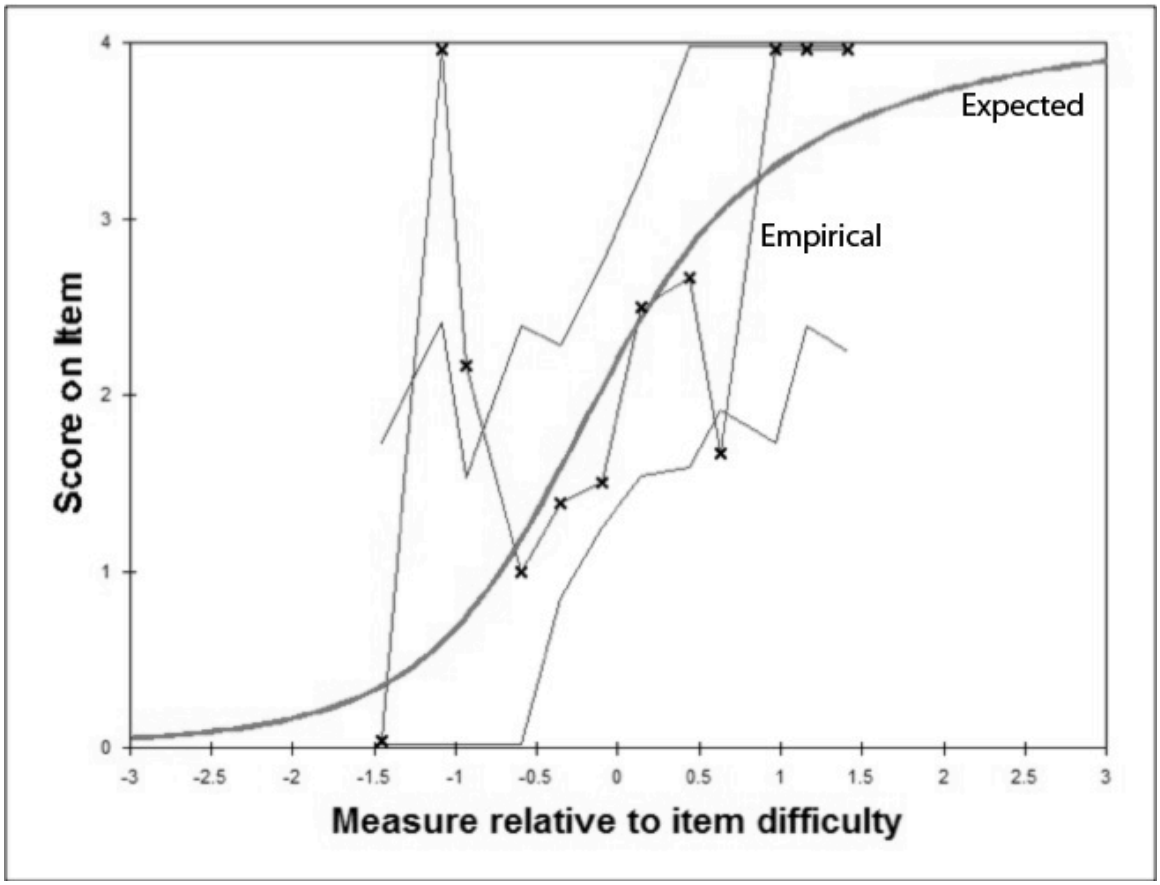

Figure 5. Item Characteristic Curve for item 1 from the Silencing the Self Scale. The "expected" curve represents the expected item performance, and the "empirical" curve with cross-marks represents the actual performance of item 1. Two additional lines (without cross-marks) represent the upper and lower 95% confidence interval quality control lines.

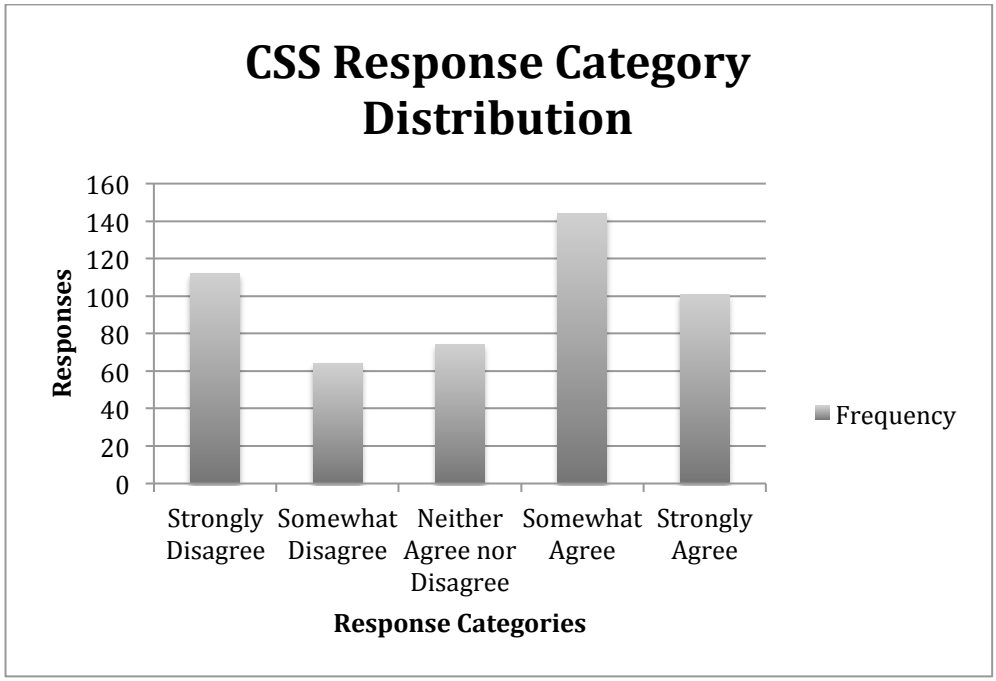

Figure 6. The Care as Self Sacrifice subscale response category distribution for 55 participants and 9 items.

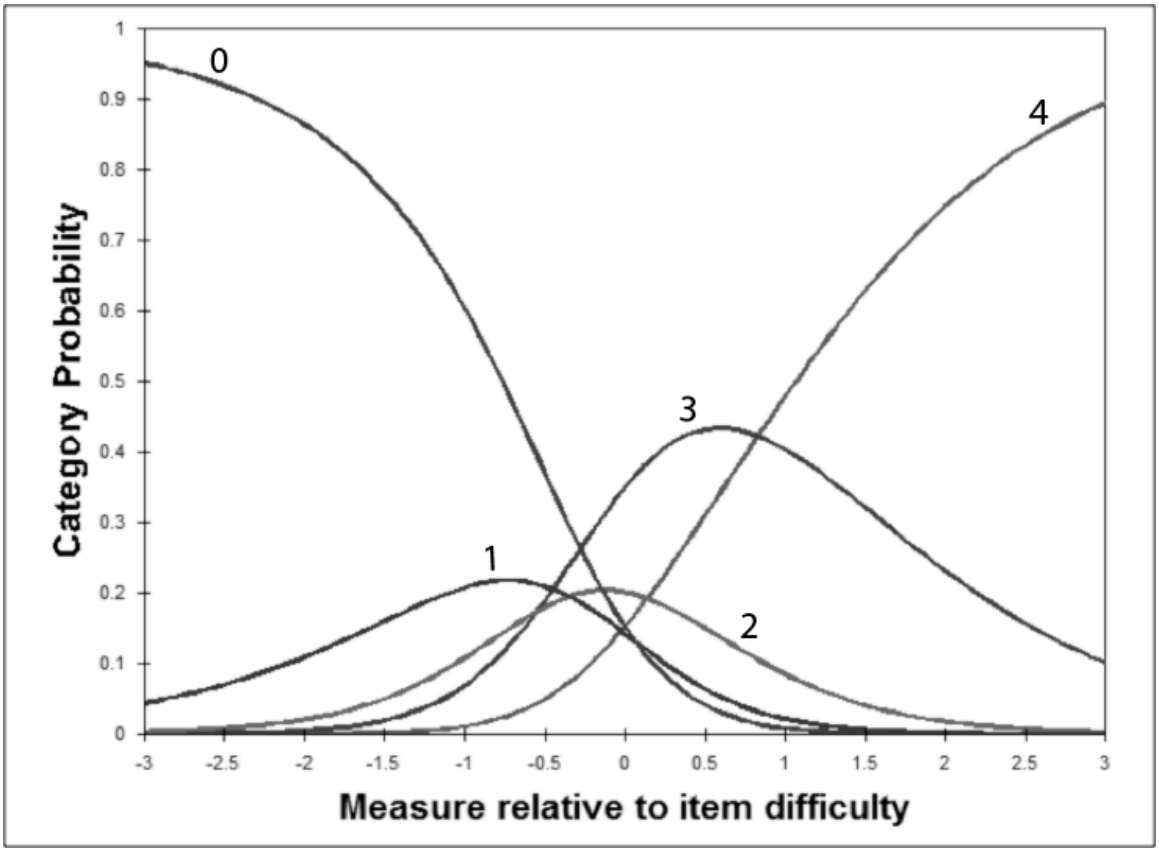

Figure 7. Response category probability curves for the Care as Self Sacrifice subscale. Y-axis indicates category probability, or the likelihood of endorsement. X-axis indicates the person estimate (measure) subtracted from item difficulty. Zero indicates response category *strongly disagree*; 1 indicates response category *somewhat disagree*; 2 indicates response category *neither agree nor disagree*; 3 indicates response category *somewhat agree*; 4 indicates response category *strongly agree*.

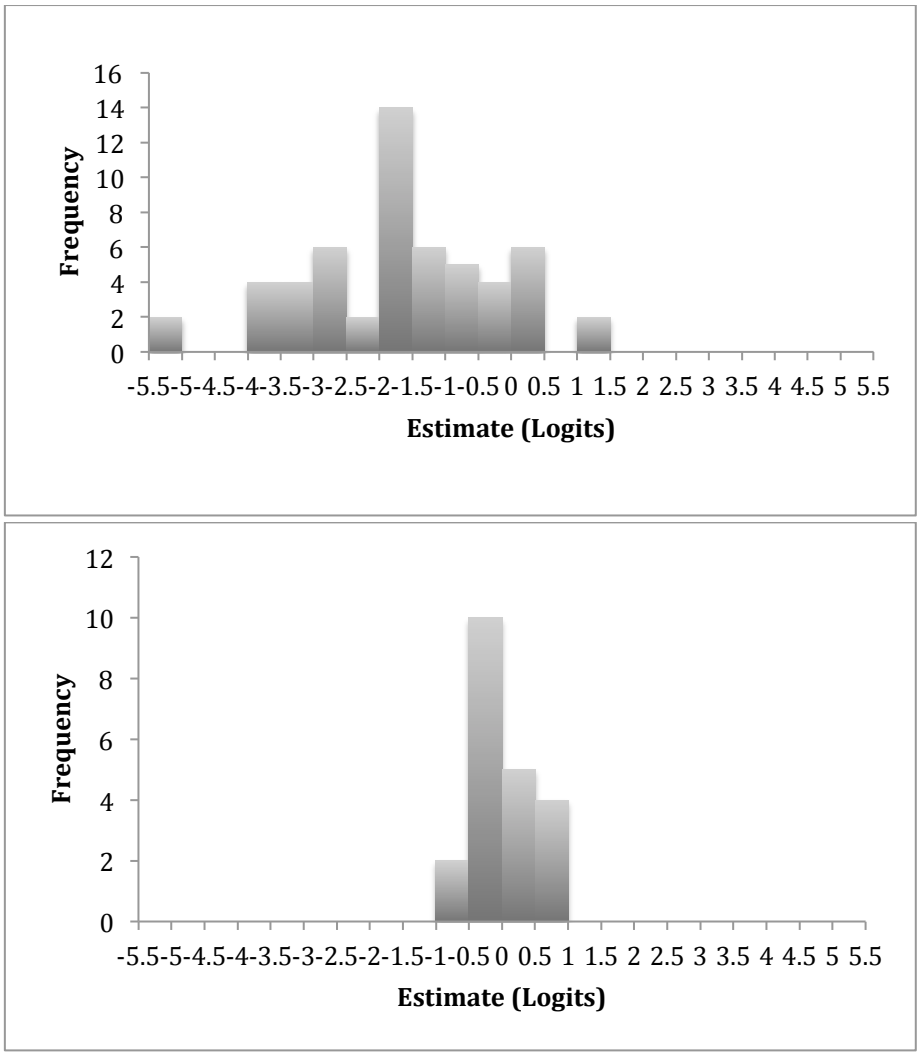

Figure 8. Frequency distributions of participant performances on the Beck Depression Inventory II (top) and the Beck Depression Inventory II item performances (bottom). Zero logits is the total item estimate mean. Item N = 21; Participant N = 55.

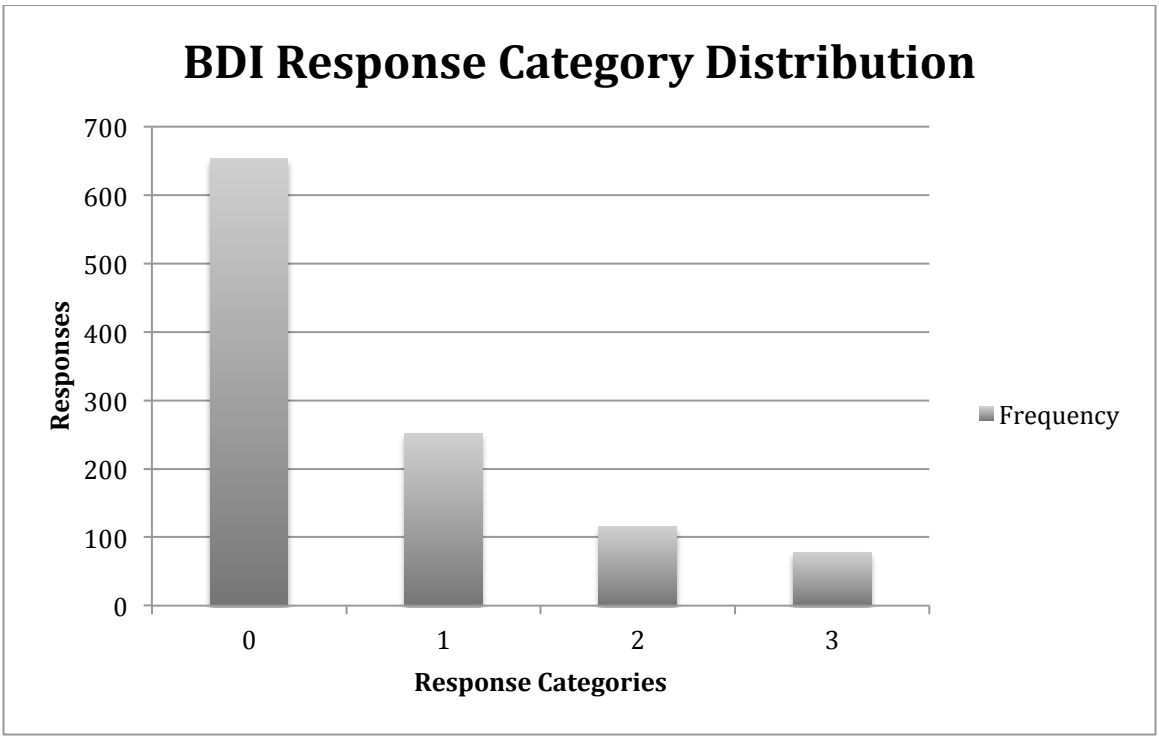

Figure 9. The Beck Depression Inventory II response category distribution for 55 participants and 21 items.

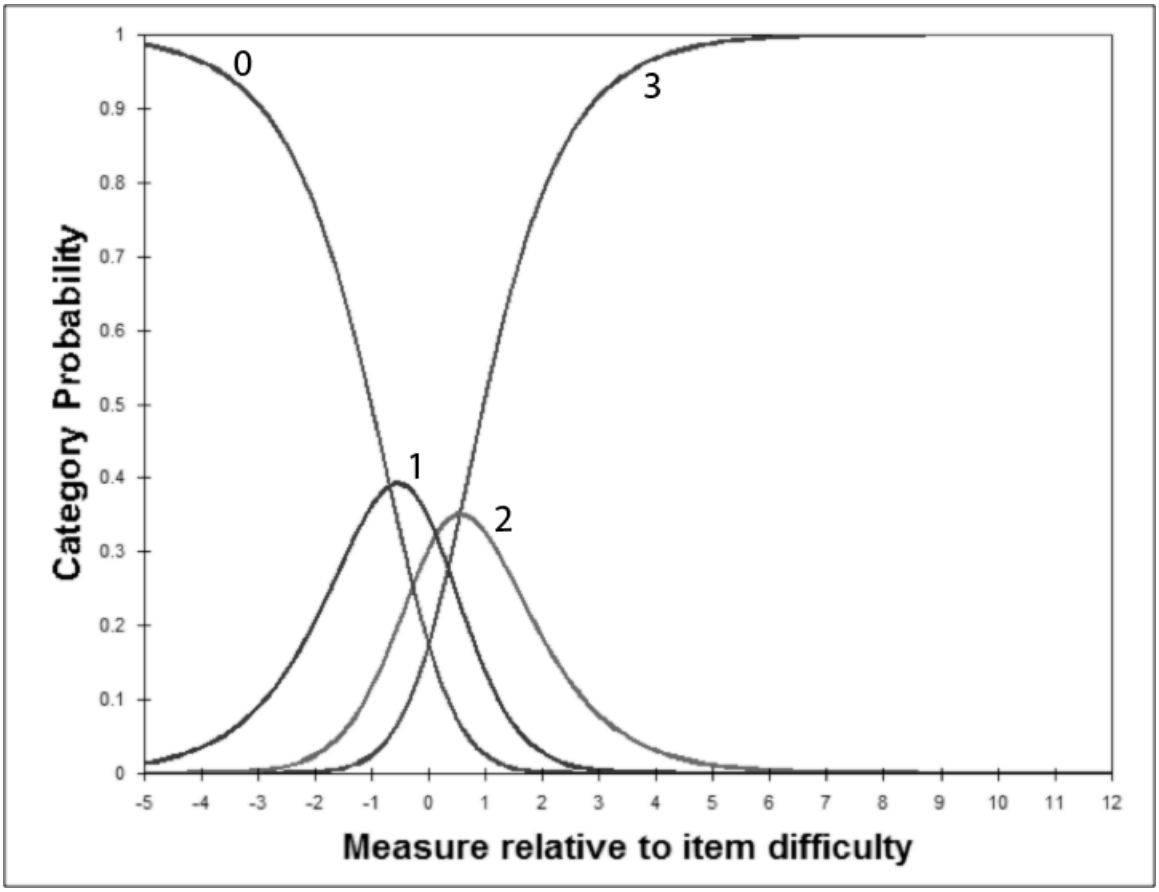

Figure 10. Response category probability curves for the Beck Depression Inventory II. Y-axis indicates category probability, or the likelihood of endorsement. X-axis indicates the person estimate (measure) subtracted from item difficulty. Zero indicates the lowest response category for the item (lowest level of depression) and 3 indicates the highest response category for the item (highest level of depression).

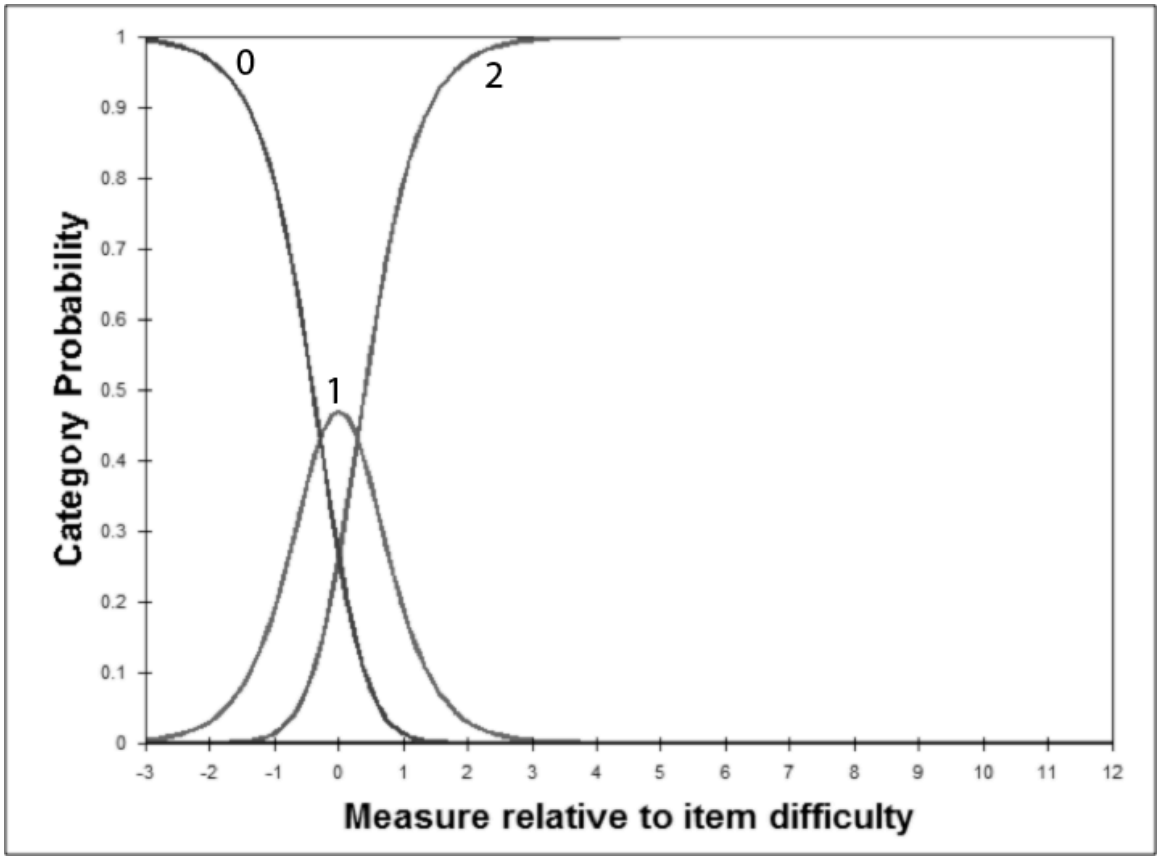

Figure 11. Response category probability curves for the calibrated Silencing the Self Scale. Y-axis indicates category probability, or the likelihood of endorsement. X-axis indicates the person estimate (measure) subtracted from item difficulty. Zero indicates response categories *strongly disagree* and *somewhat disagree*; 2 indicates response category *neither agree nor disagree*; 3 indicates response category *somewhat agree* and *strongly agree*.

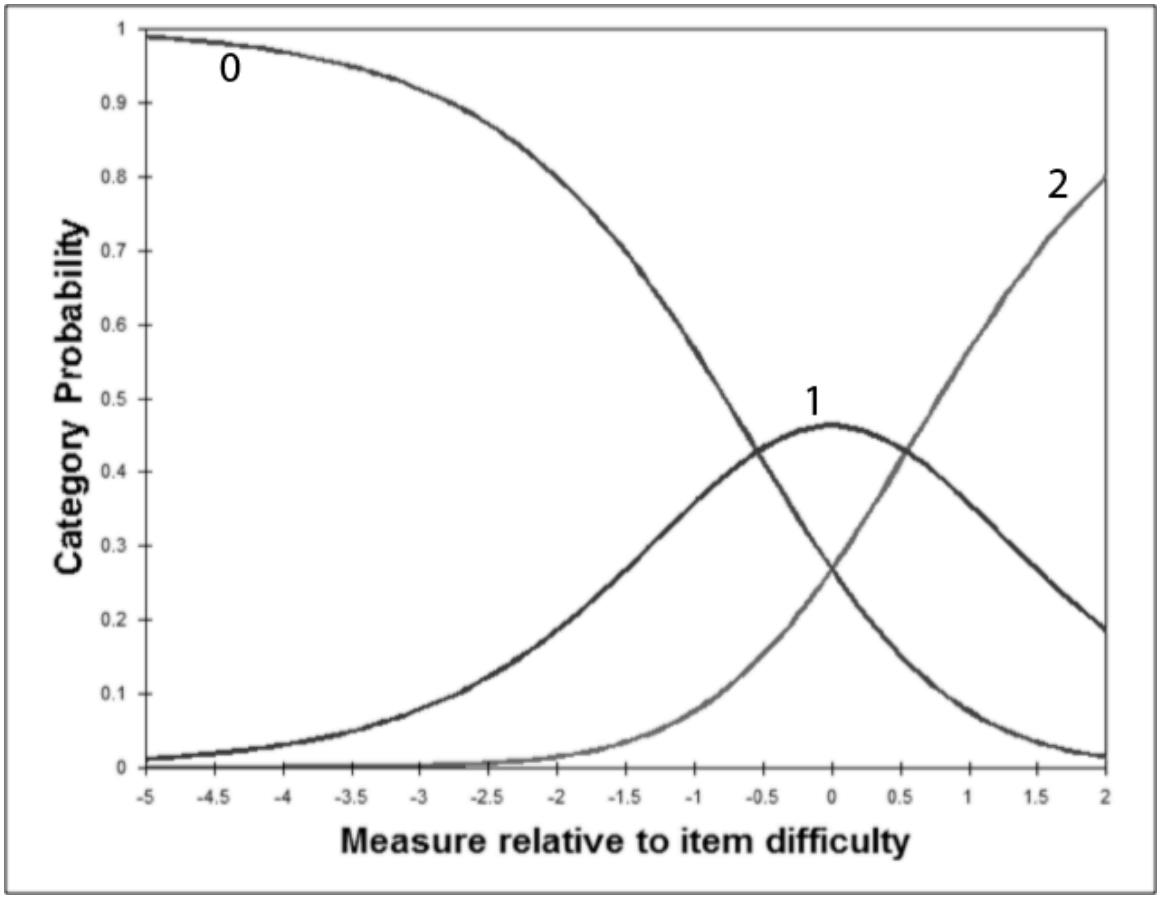

Figure 12. Response category probability curves for the calibrated Beck Depression Inventory II. Y-axis indicates category probability, or the likelihood of endorsement. X-axis indicates the person estimate (measure) subtracted from item difficulty. Zero indicates the original response categories 0 and 1 for the item (lower levels of depression); 1 indicates original response category 2; 3 indicates original response categories 3 and 4 (higher level of depression).

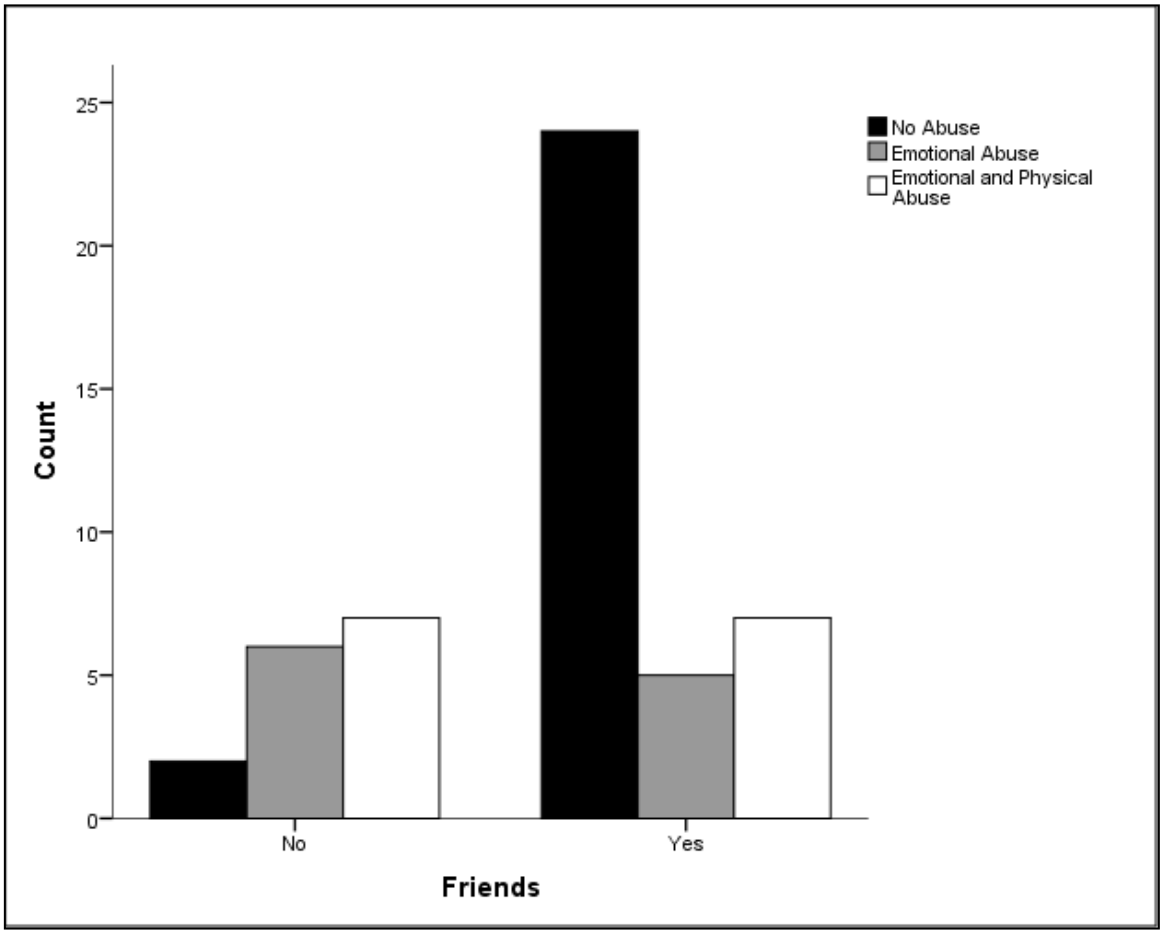

Figure 13. Participant counts for reports of friend and reports of abuse; $N = 51$.

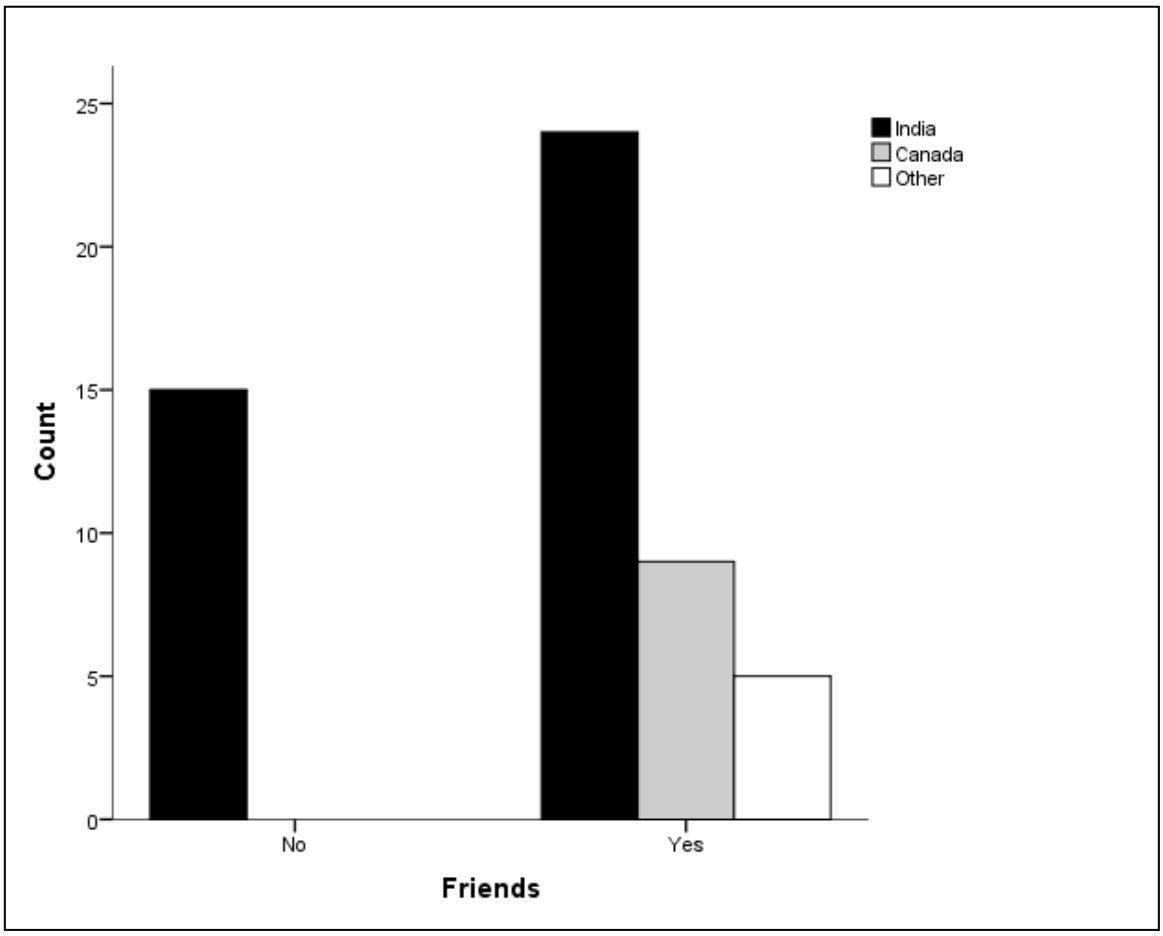

Figure 14. Participant counts for reports of friend and birthplace; $N = 53$.

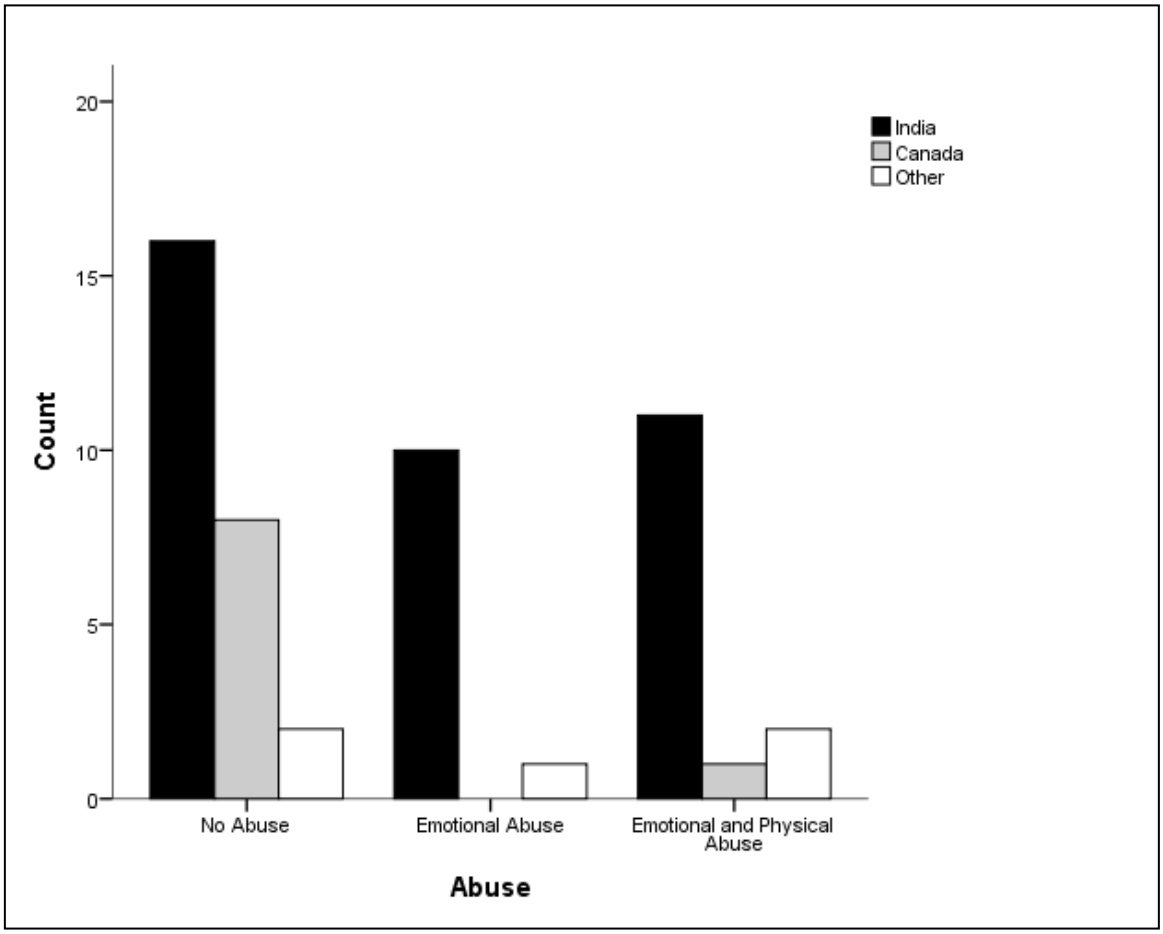

Figure 15. Participant counts for reports of abuse and birthplace; $N = 52$.

Appendix A: Silencing the Self Scale

Please circle the number that best describes how you feel about each of the statements listed below. If you are not currently in an intimate relationship, please indicate how you felt and acted in your previous intimate relationships.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

1. I think it is best to put myself first because no one else will look out for me

   1 2 3 4 5

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

   1 2 3 4 5

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

   1 2 3 4 5

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

   1 2 3 4 5

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

   1 2 3 4 5

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

   1 2 3 4 5

7. I feel dissatisfied with myself because I should be able to do all the things people are supposed to be able to do these days.

   1 2 3 4 5

8. When my partner's needs and feelings conflict with my own, I always state mine clearly.

   1 2 3 4 5

9. In a close relationship, my responsibility is to make the other person happy.

   1 2 3 4 5

10. Caring means choosing to do what the other person wants, even when I want to do something different.

    1 2 3 4 5

11. In order to feel good about myself, I need to feel independent and self-sufficient.

    1 2 3 4 5

Strongly	Somewhat	Neither agree	Somewhat	Strongly

disagree	disagree	nor disagree	agree	agree

12. One of the worst things I can do is to be selfish.

1	2	3	4	5

13. I feel I have to act in a certain way to please my partner.

1	2	3	4	5

14. Instead of risking confrontations in close relationships, I would rather not rock the boat.

1	2	3	4	5

15. I speak my feelings with my partner, even when it leads to problems and disagreements.

1	2	3	4	5

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

1	2	3	4	5

17. In order for my partner to love me, I cannot reveal certain things about myself to him/her.

1	2	3	4	5

18. When my partner's needs or opinions conflict with mine, rather than asserting my own point of view I usually end up agreeing with him/her.

1	2	3	4	5

19. When I am in a close relationship I lose my sense of who I am.

1	2	3	4	5

20. When it looks as though certain of my needs can't be met in a relationship, I usually realize that they weren't very important anyway.

1	2	3	4	5

21. My partner loves and appreciates me for who I am.

1	2	3	4	5

22. Doing things for myself is selfish.

1	2	3	4	5

23. When I make decisions, other people's thoughts and opinions influence me more than my own thoughts and opinions.

1	2	3	4	5

24. I rarely express my anger at those close to me.

1	2	3	4	5

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

25. I feel that my partner does not know my real self.

    1 2 3 4 5

26. I think it is better to keep my feelings to myself when they do conflict with my partner's.

    1 2 3 4 5

27. I often feel responsible for other people's feelings.

    1 2 3 4 5

28. I find it is hard to know what I think and feel because I spend a lot of time thinking about how other people are feeling.

    1 2 3 4 5

29. In a close relationship I don't usually care what we do, as long as the other person is happy.

    1 2 3 4 5

30. I try to bury my feelings when I think they will cause trouble in my close relationship(s).

    1 2 3 4 5

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

    1 2 3 4 5

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

Appendix B: Coding Manual

Subscales of the Silencing the Self Scale:

1. **Externalized Self Perception** assesses for schema regarding standards for self-judgment and includes the extent to which a person judges the self through external standards. Example Questions: 6. Question 31 also may assess for this by finding for self, gender, and culture specific standards.

2. **Care as Self Sacrifice** measures the extent to which relationships are secured by putting the needs of others ahead of the needs of self. Shows hierarchy between relationships, shows a standard for negative self-judgment if woman does not comply with this. Example Questions: 4.

3. **Silencing the Self** asses the tendency to inhibit self-expression and action in order to secure relationships and void retaliation, possible loss, and conflict. Measures both behavioral and phenomenological self-silencing. Example Question: 30.

4. **Divided Self** measures the extent to which a person feels a division between an outer "false" self and inner-self resulting from hiding certain feelings and thoughts in an important relationship. Characterized by a mode of relating through compliance to the partner's wishes and that the feelings hidden were oppositional or angry, challenging one. Example Question: 16.

Many passages may show multiple themes. Write the abbreviations below themes and then write a more descriptive explanation for each theme exemplified. Example, for an abuse narrative: AB, husband's drinking is the reason for the abuse.

- **Divided Self (DS)**
  - Look for "I act," "I have to" or something of the like to show that it is not their natural way of behaving.
  - Look for words like "angry, or rebellious" that show that the woman is not happy with how she has to be.
- **Care as Self Sacrifice (CSS)**
  - Look for "put other's first," "I come last," and "thinking about others."
  - Code who the woman is sacrificing her needs for.
- **Silencing the Self (SS)**
  - Code any reference and reason for the silencing.
  - Code Who the silencing is towards.
- **Externalized Self Perception (ESP)**
  - Look for Criticism or Judgment, anything that makes the woman think she's "bad."
  - Look for "their" standards. Any reference to woman is referring to an externally created or enforced standard.
- **Entrapment (ENT)**
  - Code for forms of entrapment that is related to "the family."
  - Code for forms of entrapment related to the "community" or "society."
  - Code for forms of entrapment that are specific to being an immigrant.
  - **Abuse (AB)**
    - Code any reference to physical or emotional abuse.
    - Code what the abuse is fostered by.
- **I Lose Myself (LS)**
  - Code any reference to "loss of [her]self" and reason for loss of self.
- **Inequality (INE)**
  - Code for any reference to woman is not equal to any other group/person.
    - Note the specific inequality.

        - Note any emotional cue words.
- **Standards and Expectations of a Woman**
    - Code any reference to responsibilities, expectations, and standards.
    - Code if the reference is a self-imposed standard or an external standard.
- **Code for references to the effects of abuse and family conflict for children. (CHILD)**

*****For Coding the depression Questions- For any reference to depression, ALSO CODE FOR what subscale of the Silencing the Self Scale the reference is concurrent with (if applicable). *****

- **How does one experience depression? (DEXP)**
    - Code any reference to HOW depression is experienced.
- **What causes depression? (DCAS)**
    - Code any given reasons that lead to depression.
- **What can help cure depression? (DCUR)**
    - Code any given "treatment" for depression.