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Marital distress and depressive symptoms in women:

The effects of self-silencing and self-complexity

Brian J. MacDonald

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0-612-66168-7

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Abstract

Marital distress and depression are strongly related, making the study of depression within a marital context particularly interesting. Causal models suggest that men's depressive symptoms precede marital dissatisfaction, whereas women's depressive symptomatology follows marital dissatisfaction. Few such models have integrated husbands' and wives' variables in a single model. The present study tested a model that predicted depressive symptoms in married women using marital dissatisfaction, self-silencing, and husbands' depressive symptoms. Jack's (1991) theory predicted that self-silencing would be more likely to occur in women for whom the marital role was central to the self-concept. A community sample of eighty-five couples completed the Beck Depression Inventory, and the Revised Dyadic Adjustment Scale. A measure self-image complexity was included to determine the extent to which subjects defined themselves in terms of their marital relationships. A "domino effect" was supported in predicting women's, but not men's, depressive symptoms: depressed husbands tended to be dissatisfied with their marriages, which increased the likelihood that their wives would also be dissatisfied, which was related to the women's vulnerability to depressive symptoms. Silencing one's needs and feelings within relationships was also associated with an increase in women's depressive symptoms, and was particularly likely to occur when the husbands reported depressive symptoms. Contrary to Jack's (1991) self-silencing theory, silencing was less likely to occur in women who defined themselves in terms of their marital relationships. This finding is in agreement with research examining relationships between conflict management techniques and particular attachment styles. Individuals who are preoccupied with their relationships, who are likely to define themselves in terms of those relationships, tend not to silence their needs and

feelings. In contrast, individuals who avoid closeness in relationships, who are unlikely to define themselves in relationship terms, tend to withdraw from conflict and censor their feelings in interactions with their partners. Further research is needed in order to clarify the association between the centrality of relationships to one's sense of self and the silencing of needs and feelings within those relationships.

Marital distress and depressive symptoms in women:

The effects of self-silencing and self-complexity

There is a preponderance of research linking marital distress to both major depression (e.g., Beach, Martin, Blum, & Roman, 1993; Coleman & Miller, 1975; Johnson & Jacob, 1997) and depressive symptoms (e.g., Aseltine & Kessler, 1993; Beach & O'Leary, 1993a; Beach & O'Leary, 1993b; Cohan & Bradbury, 1997; Culp & Beach, 1998; Horneffer & Fincham, 1996; Tower & Kasl, 1995; Ulrich-Jakubowski, Russell & O'Hara, 1988; Whiffen & Gotlib, 1989), especially in women. This association is so strong that Gollan, Gortner, and Jacobson (1996) argued that affective disorders should be diagnosed within a relational framework, and they created a new diagnosis: Partner Relational Affective Disorder. Although researchers agree that depressive symptoms and marital distress are related, there is currently some debate about the temporal relationship between the two.

The approximate 2:1 ratio of clinically depressed women to men in developed countries (American Psychiatric Association, 1994; Culbertson, 1997; Nolen-Hoeksema, 1987) appears to be stable to date, and has made gender differences in the etiology, experience, and course of depression a particularly interesting field of study. The gender difference in the incidence of depression emerges during adolescence (Nolen-Hoeksema & Girgus, 1994), and several theories have been advanced to explain it. In a broad review of the depression literature, Nolen-Hoeksema and Girgus (1994) concluded that, although there is no current theory that conclusively explains the gender difference, evidence of risk factors is present in girls from an early age. These interact with the biological and social challenges of adolescence and result in an increased risk for the development of depressive symptoms. Nolen-Hoeksema and Girgus

(1994) reported that pre-adolescent girls are more likely than boys to have a co-operative social interaction style and a ruminative coping style. Nolen-Hoeksema (1991) proposed that the ruminative coping style, which is used more often by women than by men and which is related to depressive symptomatology, may influence the gender difference. These risk factors, combined with the physical changes that occur during adolescence, the increased risk of sexual abuse and harassment, and interactions with males whose interaction style is domineering, make women vulnerable to depression. Bebbington (1996) also concluded that current theories concerning the gender difference in rates of depression have not yet conclusively explained the difference. However, he argued that social and psychological gender differences are the most promising areas of research to explain the gender difference in the occurrence of depression. He made particular note of female vulnerability arising from role conflict and the possible buffering effects of multiple roles on depressive symptoms.

The present study was designed to examine the role of marital distress in explaining gender differences in depressive symptoms, and what seems to be a vulnerability in women to depressive symptoms related to marital problems. Why might women be vulnerable to depressive symptoms when their marriages are distressed? Jack (1991) proposed that women are socialized to over-emphasize the importance of their roles as wives and mothers. She argued that, in order to maintain these relationships, and to cope with their own marital dissatisfaction, women silence their needs and feelings. Jack believes that problems in marital relationships pose a threat to women's sense of self, and that "self-silencing" leads to depression and anxiety when women are unable to live up to their high expectations of what their relationships should be. Other researchers have also hypothesized that negative events lead to depressive symptoms,

but argued that a complex self-representation, in which the self-concept is made up of several independent aspects, could buffer against depressive reactions (Linville, 1985; Cohen, Payne & Smith, 1997; Smith & Cohen, 1993).

The present study was designed to test a model in which "self-silencing" partially mediates the relationship between marital distress and depression in women. The model also examined the relationship between self-silencing and "self-complexity," which refers to the complexity of one's self-representation. Self-complexity is, in part, determined by the number of roles one takes. Initially, evidence for a relationship between marital distress and depression will be presented, with special attention paid to the temporal nature of this relationship. Evidence for gender differences in the association between marital problems and depression will also be discussed. Explanations for this difference will next be examined, focusing on self-silencing in particular. Research related to vulnerability arising from a self-concept devoted primarily to the marital relationship will be presented, along with evidence for the buffering effects of a complex self-representation. This will lead to a discussion of the hypotheses to be tested in the present study.

Throughout this review, a distinction has been made between self-reported depressive symptoms and clinically diagnosed depression. Some researchers treat the depressive syndrome and its symptoms as analogous. However, there may be important differences between the two. For example, self-report measures of depression often do not take into account other disorders that may preclude a diagnosis of depression, such as substance abuse or a general medical condition. A review by Coyne (1994) concluded that "self-reported distress is not an adequate marker for diagnosable depression" (p. 40), due to conceptual differences between depressive

symptoms and Major Depression, as well as differences in the prevalence and stability of symptoms as opposed to diagnoses. In addition, studies using Major Depression as the criterion may yield different results from those using self-report measures. Other researchers do not concur with Coyne's (1994) arguments. Some reviews of the depression literature have concluded that there is continuity between depressive symptoms and the depressive syndrome, and that clinical depression falls at one end of a continuum, with its symptoms at the other end (Flett, Vredenberg & Krames, 1997; Vredenberg, Flett & Krames, 1993). Nonetheless, in order to describe accurately the studies reviewed here, a distinction has been made between findings concerning diagnosed depression (hereafter termed "clinical depression," "Major Depression," or simply, "depression"), and those using self-report measures (referred to as "depressive symptoms" or "symptomatology"). Note, however, that the literature review has not been separated according to this dichotomy.

Depression and marital distress

As early as the 1970s, researchers were investigating the relationship between marital distress and psychological problems. Interpersonal theories of depression arose, in part, from studies in which clinically depressed women reported marital discord prior to the onset of their depressive symptoms (e.g., Paykel, Myers, Dienelt et al., 1969; Weissman & Paykel, 1974), and in which the lack of a supportive, intimate relationship with a husband or boyfriend was identified as a risk factor for clinical depression in women (Brown & Harris, 1978). The development of interpersonal theories of depression was also greatly influenced by research examining the interactions of depressed people. People who report depressive symptoms elicit negative reactions from others (e.g., Coyne, 1976a; Gotlib & Robinson, 1982; Joiner, Alfano, &

Metalsky, 1992; Strack & Coyne, 1983; Tan & Stoppard, 1994). The interactions between clinically depressed inpatients and their spouses have been found to be more negative than those with strangers (Hinchliffe, Hooper & Roberts, 1978), and leave spouses feeling hostile, angry, and competitive, and less agreeable and nurturant (Kahn, Coyne & Margolin, 1985). These findings led to theories suggesting that the negative interactions of depressed people, which occur more often and are more negative within the marital relationship than with strangers (Hinchliffe, Hooper & Roberts, 1978), lead to a reduction in marital satisfaction (e.g., Coyne, 1976b).

These theories make the examination of depression within the context of the marital relationship particularly interesting. Studies examining depression in this way collect both correlational and longitudinal data. Although correlational evidence indicates that there is a strong association between depression or depressive symptoms and marital distress or dissatisfaction (see below), these studies cannot address the temporal nature of this relationship. Currently, there is some debate over whether marital distress precedes, and perhaps plays a role in the development of depressive symptoms, or whether depressive symptomatology leads to marital dissatisfaction. Longitudinal studies have examined the impact of marital dissatisfaction on later depressive symptoms and vice versa. However, a correlation between marital distress at one point in time and depressive symptoms at another does not control for the concurrent correlation between the two variables. Regression analyses can control statistically for these effects, but not for other possible causal paths that may influence the association. The strongest evidence regarding the causal relationship between depressive symptomatology and marital distress comes from studies using causal modeling techniques to interpret their data. These

statistical methods allow researchers to take a confirmatory, rather than exploratory, approach to hypothesis-testing, providing a test of theoretical models, and information about the fit of these models to the collected data (Byrne, 1998). In addition, cross-sectional associations and alternative causal paths can be controlled. Each type of study (correlational, longitudinal, causal models) will therefore be examined separately.

The association between marital distress and depression. Diagnoses of depression, made either by therapists or by trained raters using a structured interview, are correlated with ratings of marital conflict (Coleman and Miller, 1975) and marital dissatisfaction (Beach, Martin, Blum, & Roman, 1993; Whisman, 1999). Depressive symptoms are also associated with self-reports of marital dissatisfaction in young and middle-aged adults (Aseltine & Kessler, 1993; Beach & O'Leary, 1993a; Beach & O'Leary, 1993b; Cohan & Bradbury, 1997; Culp & Beach, 1998; Horneffer & Fincham, 1996; Olin & Fenell, 1989; Tower & Kasl, 1995; Ulrich-Jakubowski, Russell & O'Hara, 1988; Whiffen & Gotlib, 1989), as well as the elderly (Sandberg & Harper, 1999). This relationship is so strong that O'Leary, Christian and Mendell (1994) concluded that individuals experiencing marital discord are ten times more likely than happily married people to experience depressive symptoms.

Interestingly, gender differences have been observed in this relationship. The association between marital distress and depressive symptomatology appears to be stronger for women than for men (Aseltine & Kessler, 1993; Dehle & Weiss, 1998; Olin & Fenell, 1989, Sandberg & Harper, 1999). Johnson and Jacob (1997) used a cut-off score on a self-report measure of depressive symptoms to divide a sample of men and women into "depressed" and "non-depressed" groups. Although the men in their study had a greater number and severity of

depressive symptoms than did the women, couples with a "depressed" wife had more negative interactions and less positive communication than did other couples. The less severe symptoms of the women in the study were related to more severe marital consequences. Although women's depressive symptoms are related to their own and their husband's marital satisfaction, this does not appear to be the case for men (Olin & Fenell, 1989; Sandberg & Harper, 1999). For instance, Whiffen and Gotlib (1989) found that when husbands were maritally distressed, both partners exhibited depressive symptoms. However, husbands of women who reported marital distress did not differ from the husbands of non-distressed women. Thus, men may be less likely than women to react to their partners' distress, whereas women may be at greater risk for depressive symptoms when their husbands are maritally distressed. Finally, depressive symptoms in women appear to be related to overall marital satisfaction within the couple, whereas men's symptoms are associated with specific aspects of the marriage. Olin and Fenell (1989) found that only the Consensus subscale of the Dyadic Adjustment Scale (DAS) was significantly correlated with men's self-ratings of depressive symptoms, but all subscales of the DAS were significantly related to depressive symptoms in women. Depressive symptoms seem to be more strongly related to a greater range of marital difficulties for women than for men.

The results of these studies suggest that women may be more vulnerable than men to a wider range of problems in their intimate relationships (Olin & Fenell, 1989), and that they are also vulnerable to their partners' distress. However, as mentioned above, longitudinal data are required to examine the temporal nature of the association between marital distress and depressive symptoms.

Longitudinal studies of depressive symptoms and marital quality. In a longitudinal study, Whisman and Bruce (1999) found a relationship between marital problems and clinical depression. They reported that marital dissatisfaction, as assessed by a single-item measure, predicted diagnoses of clinical depression at a 12 month follow-up. In fact, dissatisfied, nondepressed spouses were 30% more likely than satisfied spouses to receive a diagnosis of major depression one year after the initial assessment. Beach and O'Leary (1993a) reported a similar association between marital variables and later depressive symptoms. They obtained information about the marital adjustment and depressive symptoms of 241 couples in New York state at three time periods: one month prior to subjects' marriage, and at six and eighteen months after their marriage. Premarital relationship quality predicted depressive symptoms 18-months later.

Marital disruption, such as separation or divorce, also has an impact on later depressive symptoms, and there appears to be gender differences in this relationship. In a community sample of over 1700 married men and women, the effects of marital disruption were examined over a three-year period (Aseltine & Kessler, 1993). Among subjects who separated or divorced, but who did not remarry during the 3 years between assessments, marital disruption was related to an increase in depressive symptoms after controlling for initial symptoms, social relationships and supports, financial resources, role demands, and initial marital quality. This relationship was stronger in women than in men. When the effects of serious marital problems at the initial assessment were taken into account, separation or divorce was related a decrease in symptoms in men but not in women (Aseltine & Kessler, 1993). For men, removing themselves from a

stressful relationship alleviated depressive symptoms, whereas women continued to have problems even after such a relationship ended.

Other research suggests that distress within the marriage may exacerbate or prolong existing depression. In a 9-month follow-up study conducted by Hooley and Teasdale (1989), clinically depressed women who reported high levels of marital satisfaction were less likely to relapse than were those who were dissatisfied. Interestingly, this study found that perceptions of spousal criticism could influence the course of women's depression. Women with a critical spouse were found to be more likely to relapse within 9 months of being discharged from a psychiatric hospital than were women whose husbands were not critical. In fact, none of the women who rated their spouses as being very low on criticism experienced a relapse during the study. Spousal criticism more strongly predicted relapse rates than did marital dissatisfaction. Subsequent researchers have also found relationship factors to have an impact on the course of married women's clinical depression. Whiffen, Kallos-Lilly, and MacDonald (in press) reported that, when husbands were insecurely attached, clinically depressed women were less likely to have recovered from their depressive episodes 6 months later.

Although there is evidence that marital problems can precede depressive symptoms, there are equally convincing longitudinal data supporting the opposite temporal relationship. In a cross-sectional study, Whiffen and Gotlib (1989) found that, although women's depressive symptoms did not influence the marital satisfaction of their husbands, women whose husbands reported depressive symptoms experienced lower levels of satisfaction than did those whose husbands were symptom-free. Beach and O'Leary (1993b) reported similar gender differences in a longitudinal re-examination of the sample described above (Beach & O'Leary, 1993a).

Although marital variables predicted later depressive symptomatology for all spouses (Beach & O'Leary, 1993a), husbands' premarital depressive symptoms were associated with deterioration in their own and their wives' marital satisfaction over the 18-month period (Beach & O'Leary, 1993b). Wives' depressive symptomatology predicted decline in marital satisfaction only if it was chronic. Dehle and Weiss (1998) also reported that depressive symptoms predict later marital quality, after controlling for initial marital satisfaction; however, marital quality did not predict later depression.

As in the correlational studies, longitudinal findings confirm the association between marital distress and depression. Depressive symptoms have been found both to precede and to follow marital dissatisfaction. There may also be gender differences in the relationship. Although both men's and women's marital adjustment are related to later depressive symptoms (Beach & O'Leary, 1993a), researchers have found this relationship to be stronger in women (Aseltine & Kessler, 1993; Dehle & Weiss, 1998; Olin & Fenell, 1989, Sandberg & Harper, 1999). Whereas men's depressive symptomatology affects their marriages regardless of its chronicity, women's depressive symptoms have been found to influence their later marital satisfaction only when the symptoms are chronic (Beach & O'Leary, 1993b). Women's depressive symptomatology is affected by their partner's characteristics, such as husbands' criticism, attachment insecurity, and depressive symptoms; men's symptoms seem to be more independent of their partners' characteristics and symptoms. Causal models offer important advantages over regression analyses, and represent the most convincing evidence of the temporal relationship between depressive symptoms and marital distress. However, few studies using such techniques have integrated husbands' and wives' variables in a single model.

Causal models of the marital distress/depression relationship. Ulrich-Jakubowski, Russell, and O'Hara (1988) used structural equation modeling to test three hypotheses about the relationship between marital adjustment and depressive symptoms. A cross-lagged model was used to determine whether poor marital adjustment causes later depressive symptoms, whether symptoms of depression cause later marital problems, or whether reciprocal causation occurs. The model was tested with 78 married men with a mean age of 61 years who had been married, on average, for 34 years. The men completed the Revised Symptom Checklist 90 and the Dyadic Adjustment Scale. Approximately 15 months later, the men completed the same measures. Depressive symptoms predicted marital adjustment 15 months later, after controlling for the influence of initial marital adjustment and concurrent depressive symptoms. The marital measures did not have a significant effect on later depressive symptoms. Ulrich-Jakubowski and colleagues (1988) surmised that the conflicting findings for the temporal relationship in the depression and marital distress literature may reflect a gender difference in the relationship between depression and marital problems.

Fincham, Beach, Harold and Osborne (1997) directly tested this hypothesis by examining the marital adjustment and depressive symptoms of 150 newly married couples over an 18 month period. Couples who had been married for three to eight months were randomly selected from small U.S. towns using marriage license records. Three types of models were tested separately for husbands and wives. First, cross-lagged models, similar to the one used by Ulrich-Jakubowski and colleagues (1988), were examined. For husbands, initial depressive symptoms influenced later marital satisfaction; marital satisfaction at Time 1 also affected Time 2 depressive symptoms, but to a lesser extent. For women, no significant causal relationship was

found between initial symptoms and satisfaction 18 months later. However, satisfaction influenced later symptoms. In order to test the possibility that longitudinal effects were mediated by the concurrent relationships between marital satisfaction and depressive symptoms, mediational models were examined next. Similar to the findings for the initial models, these models indicated that, for men, depressive symptoms influenced later marital satisfaction, but for women, satisfaction influenced later symptoms. Finally, a third set of analyses tested the hypothesis that a bidirectional causal relationship exists between satisfaction and depressive symptoms; that is, each plays a causal role in the development of the other. As in the previous models, depressive symptoms influenced satisfaction in men concurrently, whereas dissatisfaction led to depressive symptoms in women. These findings converge with those in the previous studies, and were replicated using different analytic techniques in the same sample (Beach, Davey & Fincham, 1999). The results of the path analyses presented above are strongly indicative of a gender difference in the causal relationship between depressive symptoms and marital satisfaction. These causal models may explain the disagreement between previous studies of this relationship regarding the temporal nature of the connection between the two variables (however, see Kurdek, 1998, for contrary findings).

Thus, longitudinal studies and structural equation models provide evidence of a causal relationship between marital dissatisfaction and depressive symptomatology in women, and indicate that, for men, depressive symptoms may play a role in the development of marital problems. Correlational studies have consistently found a relationship between women's marital satisfaction and their husbands' satisfaction, but have also reported that husbands' satisfaction is not related to the women's feelings about the marriage (e.g., Olin & Fenell, 1989; Sandberg &

Harper, 1999). The association between women's marital satisfaction and that of their husbands may be an important factor in explaining women's vulnerability to depression within marriages. It appears that husbands' depression initiates a "domino effect" within their relationships that eventually leads their wives to become depressed as well:

1. If the husband becomes depressed, he is more likely to become dissatisfied in the relationship;
2. If he becomes dissatisfied, his wife is more likely to become dissatisfied as well; and
3. If she becomes dissatisfied, she is more likely to develop depressive symptoms.

Women, then, are vulnerable not only to stressors occurring in their own lives, but also to their partners' depressive symptoms. Men, however, are less likely to be affected by their partners' depression, and are therefore less vulnerable to depressive symptomatology.

Self-silencing

Jack (1991) theorized that women's vulnerability to marital dissatisfaction arises from the manner in which women maintain their relationships, care for their partners, and cope with their negative feelings. Jack (1999) argued that gender differences in depression can be understood by examining differences in men's and women's beliefs about relationships. She hypothesized that the "ruminative" coping style that previous researchers (Nolen-Hoeksema, 1991; Nolen-Hoeksema & Girgus; 1994) proposed as an explanation for gender differences in the prevalence of depression consisted of more than just dwelling on negative thoughts. Jack (1999) argued that women are socialized to believe that they must not express negative feelings within their marital relationships, and that they must put the needs of others before their own in

order to care for them. She contended that these relationship beliefs lead women to expend a great deal of energy to maintain an outwardly compliant self, which leads to feelings of anger and depression, which must, in turn, be silenced. Ruminative coping styles and self-silencing are both learned from a young age, and both reflect a difficulty in engaging in assertive behaviours (Jack, 1999; Nolen-Hoeksema & Girgus, 1994). Jack (1999) argued that what appears outwardly to be a ruminative coping style is, in fact, the silencing of negative feelings to comply with beliefs about appropriate relationship behaviour.

Jack's (1991) theory expands on Nolen-Hoeksema's (1991) coping model by including beliefs about the relationship that lead to non-instrumental coping strategies. Self-silencing may be conceptualized as a coping mechanism that is activated in response to negative feelings that women believe will jeopardize their marital relationships. Jack's (1991) model of depression consists of several elements and coping behaviours that she considers essential to the development of depression in women. Jack (1991, 1999) believes that women are socialized to view the marital relationship as being of fundamental importance to the sense of self. She contended that many women have internalized the belief that, to be "good women," they have to be "good wives" and "good mothers." This has an important implication: relationship problems become extremely threatening to the self-concept of these women, who do not believe that they can be good people unless they succeed in the marital and maternal roles. They come to feel that they must avoid disharmony and conflict to protect their self-concepts. To see themselves as "good" wives and mothers, self-silencing women put the needs and feelings of their partners and children before their own. According to Jack (1991), they do this for two reasons: because they have internalized the notion that to do otherwise would be "selfish" and not in keeping with

their image of a "good" wife, and because putting others' needs before their own reduces the likelihood of conflict and disharmony. Caring for others comes to be equated with self-sacrifice for self-silencing women. Self-silencing theory suggests that the high standards of selflessness that these women consider to be essential to the maintenance of their marital relationships may lead to a loss of self-esteem, feelings of self-blame about relationship problems, and to depression.

Jack (1991) theorized that silencing needs and feelings within the marital relationship eventually leads to an inability to affirm or demonstrate aspects of the self. Jack proposed that women who self-silence have difficulty sustaining the feelings and convictions that they are unable to voice to their partner. That is, self-silencing women's suppression of negative feelings leads to a difficulty in maintaining the feelings being suppressed. Jack argued that women who self-silence thus begin to doubt the legitimacy of their feelings. This may be accompanied by feelings of anger at one's inauthenticity. A vicious cycle may arise, in which the self-silencing woman's inauthentic presentation of herself leads to feelings of anger, resentment and alienation, which must then be silenced. This leads to the final aspect of self-silencing: the divided self. According to Jack's theory, self-silencing women are outwardly accommodating, submissive, and self-sacrificing. Underneath, they feel angry and resentful that their needs are not being met, and hopeless about the possibility that they will ever have authentic, intimate relationships. They believe that these feelings must be silenced to maintain their relationships. Thus arises Jack's phenomenon of the "divided self," the feelings of self-alienation and hopelessness that accompany depression.

Jack (1991) developed this model by analyzing interviews with twelve clinically depressed women, ranging in age from 19 to 55. She created a measure of the relationship beliefs and behaviours described above, the Silencing the Self Scale (STSS), which consists of four rationally derived subscales. The *externalized self-perception* subscale is intended to measure the extent to which one judges oneself by external standards. The *care as self-sacrifice* subscale assesses behaviours that maintain relationships by putting others' needs before one's own. The *silencing the self* subscale measures behaviours that involve the avoidance of conflict and relationship breakdown by inhibiting self-expression. Finally, the *divided self* subscale assesses the presentation of a compliant outer self while the inner self becomes angry.

Researchers have found support for some aspects of Jack's model. Jack's (1991) theory proposed that women for whom the roles of "wife" and "mother" take on exaggerated importance may be vulnerable to depression; the enactment of the roles of "wife" and "mother" is related to depression (e.g., Bart, 1971; Pearlin, 1975; Radloff, 1975; Whitley, 1984). Self-silencing scores are also correlated with depressive symptoms among battered women living in shelters, cocaine-abusing mothers (Jack & Dill, 1992), and undergraduate women (Duarte & Thompson, 1999; Jack & Dill, 1992). Similar correlations have been obtained in community samples of married couples (Thompson, 1995), adolescents (Hart & Thompson, 1996), and college students from various ethnic backgrounds (Gratch, Bassett & Attra, 1995). Thus, the relationship between self-silencing and depressive symptoms appears to be robust. Finally, in a community sample of married men and women, Thompson (1995) found that the correlation between self-silencing and depressive symptoms was stronger for women than for men.

Another aspect of the model that has been supported is Jack's (1991) notion that current relationships influence women's self-silencing. Thompson (1995) found that women's STSS scores were related to both their own and their husband's relationship satisfaction, whereas men's silencing was unrelated to relationship factors. Thompson, Whiffen and Aube (in press) also found gender differences in self-silencing. They reported that, for men, self-silencing was related to perceptions of both parents and partners as rejecting and critical, but for women, silencing was related only to their perceptions of their romantic partners. These findings suggest that silencing is strongly tied to the marital context for women.

Studies using hierarchical regressions have found evidence of a connection between self-silencing and depression above and beyond such factors as marital dissatisfaction (Thompson, 1995). Self-silencing, particularly the *externalized self-perception* subscale, predicted depressive symptoms in adolescents of both genders, even after controlling for the effects of Nolen-Hoeksema's coping styles (Hart & Thompson, 1996). However, one study, which used a sample of undergraduates, demonstrated that the association between self-silencing and depressive symptoms only occurs in conjunction with low self-esteem (Page, Stevens & Galvin, 1996). Carr, Gilroy and Sherman (1996) reported that STSS scores predicted depressive symptoms in Caucasian women, but not in African Americans, after income and social desirability were taken into account. The research has generally supported a relationship between self-silencing and depressive symptoms that cannot be explained by marital problems, coping styles, income, or social desirability. However, this relationship may be influenced by ethnicity and self-esteem.

The basic assumption that self-silencing behaviours are related to depressive symptomatology seems to hold in diverse samples. However, research evidence has not consistently supported Jack's (1991) model. Two important findings that have been demonstrated repeatedly are that self-silencing and depressive symptoms are related in men as well as women (Duarte & Thompson, 1999; Gratch, et al., 1995; Hart & Thompson, 1996), and that men obtain higher STSS scores than do women (Gratch et al., 1995; Thompson, 1995). In studies of undergraduates, men have also been found to obtain higher scores than women on three of the four STSS subscales (Duarte & Thompson, 1995; Page et al., 1996). Another aspect of Jack's (1991) theory that has not been consistently supported is the unique association between depression and self-silencing among women. Although Thompson (1995) found that self-silencing was more strongly associated with depressive symptoms for married women than for married men, neither Gratch and colleagues (1995) nor Page and colleagues (1996) found this gender difference among unmarried undergraduates. Jack (1991) hypothesized that the present marital relationship influenced self-silencing and depressive symptoms, and it is possible that self-silencing among students may differ from silencing within marriages.

Generally, the research indicates that there are gender differences in self-silencing: men silence to a greater extent than do women, and women's silencing may have a closer connection to depressive symptoms than does men's silencing, at least among married men and women. Most researchers believe that men and women self-silence for different reasons. In fact, Duarte and Thompson (1999) found that two subscales of the STSS, Divided Self and Care as Self-Sacrifice, were correlated for women but not for men, an indication that the meaning of self-

silencing may differ for men and women. Several possible reasons for the gender differences on the STSS have been proposed:

1. Men are socialized to suppress emotion and affection, and therefore perceive self-silencing differently than do women (Duarte & Thompson, 1995).

2. Men self-silence to maintain power in their relationships by maintaining distance, whereas women do so to care for others and to avoid conflict (Page et al., 1996).

3. Men lack the language to discuss their feelings in relationships whereas women are *reluctant* to do so (Gratch et al., 1995).

All of these possible explanations have a common element: they each suggest that men and women are self-silencing for different reasons. A finding that is not addressed by the hypotheses outlined above is that women's self-silencing is related both to their own and their partner's relationship adjustment as well as to their own and their partner's depressive symptomatology, whereas men's silencing is not (Thompson, 1995). This finding is of particular salience in the present study, as it may be related to the greater impact of women's silencing on their depressive symptoms. Two aspects of self-silencing theory can explain the dependence of women's silencing on their partners' depressive symptoms and marital adjustment: the importance for women of maintaining their marital relationships, and the tendency for women to equate "care" with "self-sacrifice." Jack (1991) argued that women's marital relationships are central to their sense of self, and that they therefore become preoccupied with maintaining their relationships. One reason that women engage in self-silencing is to avoid conflict that might disrupt or endanger the marriage. When husbands are dissatisfied with their relationships, their wives may become anxious about avoiding conflict and

thus become more likely to self-silence. Another important aspect of self-silencing theory is that women are socialized to believe that, to be "good" wives, they must care for their romantic partners by sacrificing their own needs and silencing their feelings. It is possible that these behaviours are more likely to occur when their partners are in need of greater care (i.e., they experience depressive symptoms). Thus, Thompson's (1995) finding that women's, but not men's, self-silencing is related to factors within their marriages can be reconciled with Jack's (1991) theory. Self-silencing women, who equate care with self-sacrifice, may react to their partners' depression by putting aside their needs and feelings to care for their husbands. Under such circumstances, self-silencing may be particularly likely to lead to depression. Men's silencing is unrelated to their partners' depressive symptoms, which may indicate that husbands do not silence their needs and feelings to care for their partners. The relationship between husbands' mental health and wives' self-silencing may, in part, explain the greater impact of self-silencing on women's depressive symptoms. Husbands' characteristics must be considered in models of women's silencing.

Although both men and women self-silence, the importance of relationships to women's self-representations may also influence the association between self-silencing and negative affect, leading self-silencing women to be more vulnerable to depression than men who exhibit the same tendencies. Thompson (1995) argued that women's relationships are more central to their self-esteem than are men's, and that the inauthenticity of self-silencing in relationships may therefore have a greater impact on women. Jack (1991, 1999) considered the centrality of women's relationships to their self-concepts to be an essential factor in the development of mood problems related to self-silencing behaviours. This extreme "other-orientation" leads

silencing women to define themselves by a small number of very inter-related roles. For African-American women, for whom "multiple roles . . . appear to be the norm" (Carr et al., 1996), there does not seem to be a relationship between depression and self-silencing. Smith and Cohen's (1993) cognitive model of depression takes into account the importance placed on certain roles, particularly relationship-related roles. Women who primarily see themselves as "wives" and "mothers" are likely to see shortcomings within these roles as threatening to their self-concepts and self-esteem (Jack, 1987, 1991, 1999). Perhaps the narrow definition of the self that accompanies self-silencing in women is related to married women's tendency to become depressed in distressed relationships.

In sum, the association between depressive symptoms and self-silencing in women has been demonstrated repeatedly in numerous samples. For women, the association is influenced by self-esteem, ethnicity, and possibly by the number of roles in which they are active. Although men engage in self-silencing to a greater degree than do women, silencing within the marital relationship has less impact on their own depressive symptoms. One possible explanation for the greater impact of self-silencing on married women's depressive symptoms is the relationship between partners' mental health and silencing; women are more likely to self-silence when their partners report depressive symptoms, but men's silencing is not influenced by their partners' symptoms. Self-silencing to care for a vulnerable spouse may be particularly depressogenic. A second possible reason for the greater impact of women's silencing on their depressive symptomatology is the centrality of the marital relationship to women's self-concepts. Silencing women who emphasize their marital role over other aspects of themselves may be particularly affected by the inauthenticity of their marital relationships. Men, who are less likely to define

themselves in terms of their marriages, may be less likely to become depressed when they silence their feelings within their relationships.

Self-concept complexity

Linville (1982, 1985, 1987) argued that a person who thinks of him- or herself in only a small number of roles will have a more extreme reaction to negative events than one whose self-representation comprises a larger number of roles. Thus, a narrow definition of the self may be associated with depression. This is very much in keeping with the conclusion reached by Bebbington (1996) that differences in gender roles may be related to gender differences in the occurrence of depression. He argued that women, who are more likely than men to find themselves in a small number of roles, such as wife and mother, are at greater risk for developing depressive symptoms.

Linville's (1982, 1985, 1987) model hinges on the assumption that the self-concept is composed of a number of categories, concepts, or schema relevant to the self; she called these *self-aspects*. The number of aspects making up one's self-image depends in part on the number of roles one takes and on the various relationships (e.g., spouse, parent, friend) in which one is involved. These aspects of the self are associated with competence beliefs, allowing self-efficacy beliefs to vary across situations. The self-efficacy beliefs associated with particular aspects lead the aspects to have emotional associations, such as pride or embarrassment. Although some aspects may have solely positive or negative associations, most have a mixture of both. Success related to a particular aspect increases positive associations with it, whereas failure reduces these positive connections.

Linville's (1985) model assumes that individuals vary in the complexity of their self-images. A complex self-representation contains a large number of relatively independent aspects; a person with a less complex self-image will have fewer, more inter-related aspects. Self-complexity develops over time, with experience in a variety of roles, relationships and situations. Because self-aspects are created through experience, it stands to reason that people will differ in the number and inter-relatedness of those aspects. For example, if a man believes he cannot be a good husband unless he is a good provider, his "husband" and "provider" aspects will become associated. This complexity, according to Linville (1982, 1985, 1987), moderates affective reactions to situations. If the husband mentioned above were to fail to receive a promotion, he would probably experience negative emotions, such as sadness, as a result. This would be expected regardless of his self-image complexity. However, according to Linville's (1987) model, the lower the husband's self-complexity, the more extreme his reaction will be to not getting a promotion. If his self-complexity was very low, he might react with profound depression. When negative information about a particular aspect is received by someone whose self-image is not complex, the information will influence a large proportion of the self-concept. That is, if someone thought of him- or herself in only two roles, negative information about one of those roles would affect 50% of his or her self-image. The greater the number of roles one takes, the smaller the proportion of the self-concept that will be affected. Although Linville's (1987) model did not consider the importance of particular self-aspects, later researchers included this notion in elaborations of Linville's concepts (see below).

A person with a complex self-representation possesses a large number of relatively independent self-aspects. If an event occurs that affects one aspect, it will not affect unrelated

aspects. In addition, because there are many aspects, the effect on a particular one will be limited, since one aspect represents a relatively small proportion of the total self-image. If the same event occurred to someone with few, closely related aspects, the effect would be greater. Although the event is localized to a particular aspect, that aspect forms a larger part of the self image, so the event will influence a relatively large proportion of the self-concept. In addition, because the aspects are inter-dependent, the impact can spill over into other aspects, again resulting in greater influence. A complex self-image, therefore, can buffer against negative reactions to events.

Linville's model predicts that a complex self-representation can buffer against anxiety and depression by reducing the impact of events on affect and self-appraisal (Linville, 1982, 1985, 1987). The buffering effects of self-complexity have primarily been tested in two ways: by using laboratory manipulations such as success or failure feedback, and by comparing reactions to stressful life events between subjects with high and low self-complexity. In laboratory studies, subjects with higher self-complexity scores exhibited less extreme affective reactions and self-appraisal changes following success or failure feedback than did those with lower self-complexity ratings (Linville, 1985; Niedenthal, Setterlund & Wherry, 1992). Reactions to negative life events have been examined prospectively using affect journals, usually over a two-week period. Subjects with low self-complexity scores have been found to exhibit more variability in mood over a two-week period than those with a more complex self-representation (Campbell, Chew, & Scratchley, 1991; Linville, 1985). Linville (1987) found that stressful events occurring over a two-week period had less influence on self-reported depressive symptoms and illness (e.g., flu, menstrual cramps, body aches) for subjects with high self-

complexity scores. Similarly, Smith and Cohen (1993) found that the positive relationship between the number of negative life events and psychological distress was weaker in subjects with high self-complexity scores. Overall, the evidence suggests that a complex self-representation, one with many independent aspects, can reduce the intensity of reactions to negative events, and to stressful events in the environment. It should be noted that Linville's (1985) model has been tested only with undergraduates, using self-reported mood ratings. Thus, although it has been verified to be a buffer against self-reported psychological distress among university students, the effects of self-complexity may differ in other populations.

Existing research on women's roles dovetails with Linville's (1982, 1985, 1987) model, in that people who take fewer roles, who may have a less complex self-representation, may also be vulnerable to depressive symptoms. Repetti and Crosby (1984) argued that the gender difference in the prevalence of depressive symptoms could be explained by a "paucity of roles;" women are more likely than men to be limited to a few roles. Several studies have found that women employed in the paid labour force are less likely to experience depressive symptoms than homemakers (e.g., Roberts & O'Keefe, 1981; Rosenfield, 1980). Linville (1985) would have predicted this result, since women in the paid labour force have experiences in a work role that may provide opportunities to develop other self-aspects. Therefore, women employed outside the home may be more likely than homemakers to experience the buffering effects of self-complexity. In addition, as the self-complexity model would predict, homemakers react more strongly to negative feedback about their role than do women in the paid labour force. Keith and Schafer (1985) found that when family members negatively evaluated women's performance, homemakers were more likely than employed women to react with depressive symptoms.

Studies that have not found the expected difference in depressive symptoms between homemakers and employed women (e.g., Brown & Bifulco, 1990; Shehan, 1984) reported that their findings were explained by stress in the home, or by the number of outside sources of gratification, such as participation in organizations outside the home.

Thus, it seems that women who act in a greater number of roles, whether through employment or through participation in organizations outside the home, are less likely to exhibit depressive symptoms than are women with fewer roles. Employed men may be more likely than homemakers to act in several roles: as husbands, as fathers, and as employees. In addition, although traditional men may be pressured to emphasize achievement and their role as providers (Pittman, 1993), achievement stress may not be associated with depression (Segal, Shaw & Vella, 1989) or may not be as strongly associated as is relationship stress (Hammen, Marks & deMayo, 1985). In sum, it is possible that women who engage in few roles are more likely to experience depressive symptoms than women who work or who engage in other activities outside the home, perhaps because they are less likely to experience the buffering effects of a complex self-representation. This notion complements Jack's (1991) model, which states that the centrality of relationships to the women's sense of self, when over-emphasized to such an extent that other self-aspects are denied and silenced, can lead to depressive symptoms. However, Jack (1991) discussed women's dissatisfaction and frustration in the marital relationship, whereas Linville (1985) addressed the effects of overall life stress on university students. Other researchers have expanded the self-complexity concept to examine the effects of particular stressors, such as relationship problems, on particular aspects of the self-representation.

Self-complexity and reactions to relationship-related stressors. Linville (1982, 1985, 1987) considered the effects of overall self-complexity on reactions to aggregated life stress. Subsequent researchers have modified Linville's (1982, 1985, 1987) model, examining the interactions between particular stressors and corresponding self-aspects. It is possible that women's vulnerability to relationship distress is the result of an emphasis placed on the relationship self-aspect, such that negative information about relationships would be more salient to women, and would influence a greater proportion of the self. This may be related, as Jack (1991) believes, to ineffective interpersonal coping styles such as self-silencing. Smith and Cohen (1993) investigated the link between specific self-aspects and the perceived causes of depressive symptoms.

Smith and Cohen (1993) developed the Aspect Impact Quotient, which is a measure of the proportion of one's self-representation that is occupied by a particular aspect, taking into account the inter-relatedness of this aspect with other aspects of the self. Smith and Cohen (1993) argued that a high Relationship Impact Quotient (RIQ) indicates that relationships are very important to the individual's sense of self. This may result in a vulnerability to relationship-related stress, because the relationship occupies a large proportion of the self-concept. They found that RIQ was a significant predictor of negative responses to relationship breakup among undergraduate men and women, such as blunted sensation, emotional numbness and degree of upset. Cohen, Payne, and Smith (1997) obtained similar findings in their investigation of the relationship between the friendship self-aspect, friend-related stressors, and depressive symptoms. The friendship-related stressors occurring over a 10-week period had a greater effect on the depressive symptoms of undergraduates with a high score on the friend self-

aspect measure than on those with lower scores on the self-aspect measure. Cohen and colleagues (1997) also tested the influence of the friendship self-aspect in the laboratory by setting up an interpersonal success or failure. In this task, subjects in the "success" condition were told they had been chosen by one of their peers as a partner for a problem-solving task, based on a photograph and demographic information. Other subjects were told they had not been chosen as a partner, and would be working alone. Friendship self-aspect scores predicted reactions to this situation; aggregated self-complexity scores and other self-aspects did not.

It should be noted that, although researchers have theorized that intimate relationships are more central to women's self-representations than to men's (e.g., Jack, 1991, 1999), no gender differences were found on the RIQ measure (Cohen et al., 1997; Smith & Cohen, 1993). The lack of a gender difference in these samples may have been a result of their nature. Both Smith and Cohen (1993) and Cohen and colleagues (1997) investigated their hypotheses in non-clinical samples of university students. Samples of undergraduates are unlikely to include many traditional women for whom marital relationships are central to their self-concepts, which may have resulted in a reduction in the mean RIQ scores in this sample. In addition, students may be more likely to be focused on achievement than on the roles of wife and mother. Achievement Impact, which is calculated in the same manner as RIQ, has not been tested in laboratory studies. Given the mean age of 18 years in Smith and Cohen's (1993) sample, these students would be less likely than a community sample to act in the roles of wives and mothers.

Overall, it appears that specific stressors can interact with corresponding self-aspects, resulting in more extreme reactions to such stressors. The finding that students who defined themselves primarily in terms of their romantic relationships were more greatly affected by their

break-ups corresponds very well with Jack's (1991) self-silencing model. Jack's theory predicts that women with high RIQ scores, indicating that they define themselves in terms of their marriages, would be more likely to become depressed in the face of relationship difficulties, as Smith and Cohen (1993) found with undergraduates.

The Present Study

The literature reviewed suggests the existence of an association between husbands' and wives' depressive symptoms. Recall the "domino effect" proposed earlier: over time, depressed husbands may be more likely to become dissatisfied with their marriages, which may increase the likelihood that their wives will also become dissatisfied, which may make their wives vulnerable to depressive symptoms. Married women whose partners report depressive symptoms also tend to silence their feelings and needs, which further increases their vulnerability to depressive symptoms. Although men's silencing seems to occur independently of other relationship factors, women's silencing is associated with their own and their partners' relationship satisfaction and depressive symptoms. Jack (1991) argued that women silence their needs and their negative feelings to maintain relationships because they have internalized messages that they must be selfless. This selfless caring may be especially likely to occur when women perceive their partners as being particularly in need of care, i.e., when their partners are vulnerable as a result of feelings of dissatisfaction or depressive symptoms. Given the findings of researchers investigating self-silencing, women should be more likely to self-silence under the following conditions:

1. when they are dissatisfied in their relationships,

2. when they perceive their husbands as vulnerable (i.e., they exhibit depressive symptoms or marital dissatisfaction), and
3. when their relationships are central to their sense of self (i.e., high RIQ scores).

One possible explanation for women's vulnerability to depressive symptoms in response to marital distress is that women cope with marital problems (their own and their husbands') differently than do men; women silence their feelings when they are dissatisfied. They may also attempt to care for their vulnerable partners by putting their husbands' needs before their own, which increases the likelihood that they will develop depressive symptoms. A coping style characterized by self-silencing should, in part, mediate the relationship between women's marital satisfaction and their depressive symptoms. Self-silencing should be especially likely to occur when their marital relationships are central to women's sense of self, which should make them more anxious to maintain the status quo within their marriages. The primary goal of this study is to test a model, derived from the research findings presented above, of the connections among self-silencing, self-complexity, and depressive symptoms in a community sample. The model to be tested is shown in Figure 1, and combines husbands' and wives' variables into a single analysis to examine depressive symptoms in a relational context.

This study should also replicate the following previous findings:

1. Men should be more likely than women to engage in self-silencing.
2. Self-silencing should be associated with depressive symptoms in both sexes, but it should be more strongly associated with depressive symptoms in women than in men.

3. Finally, women's silencing, but not men's, should also be related to their own and their partners' relationship satisfaction, and to their partners' depressive symptomatology.

These hypotheses were tested in a sample of married or cohabiting couples obtained from the community. They completed self-report questionnaires measuring the severity of depressive symptoms, marital satisfaction, self-silencing, self complexity, and RIQ. This study is unique in several ways. It is the first test of Linville's (1982, 1985, 1987) and Smith and Cohen's (1993) models in a community sample. It is also the first study to assess the relationship between a quantitative measure of the centrality of relationships to the self-concept (RIQ) and self-silencing. Finally, it is the first to test a model of self-silencing and depressive symptoms in women that incorporates husbands' symptoms and marital satisfaction as precursors of women's depressive symptomatology.

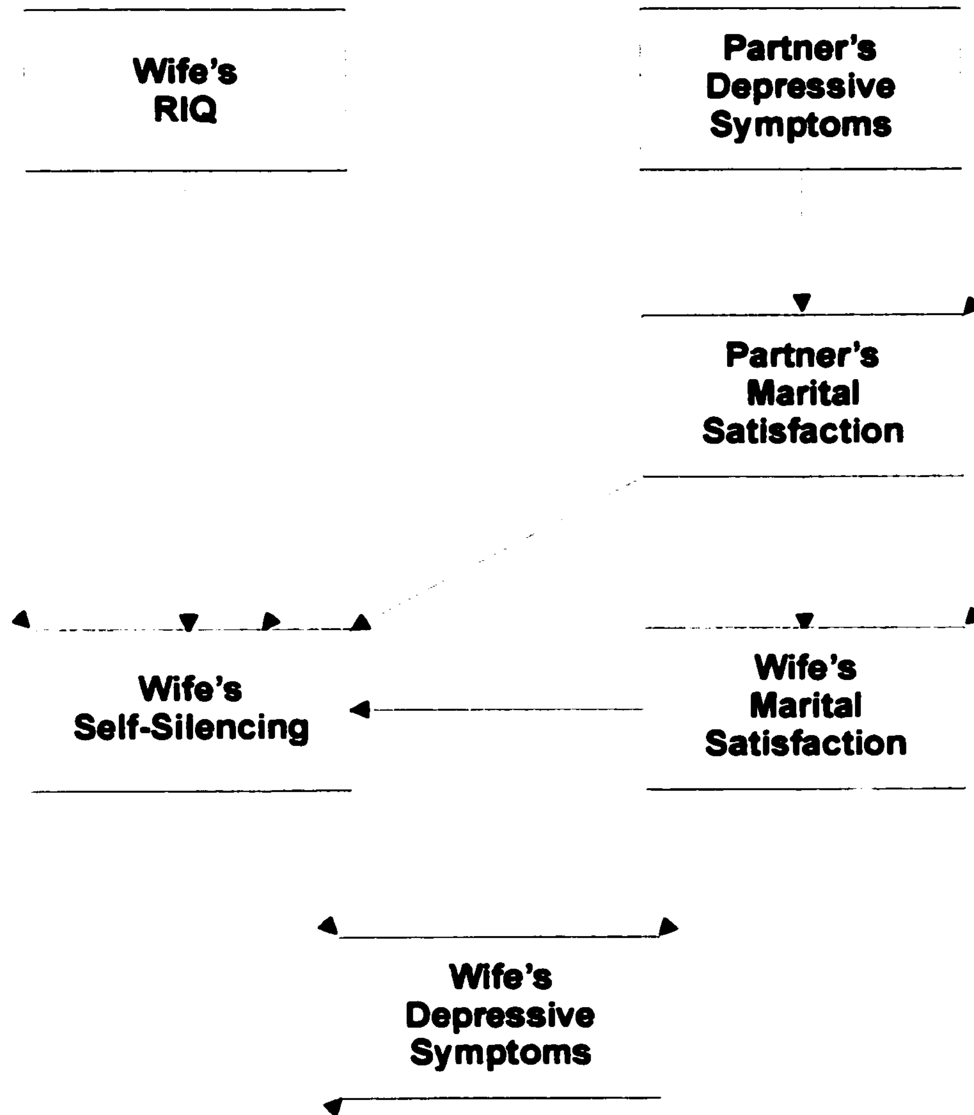

Figure 1: Model predicting the development of women's depressive symptoms in relationships.

Method

Subjects and procedure

Heterosexual couples who had been married or co-habiting for at least 6 months were recruited using advertisements in local newspapers (see Appendix A). Couples who expressed interest in the study were contacted by a research assistant who read a recruitment script (see Appendix B) and answered questions. Nearly all of the couples who were contacted agreed to participate in the study. Although both married and co-habiting couples participated in the study, male and female partners will hereafter be referred to as husbands and wives, respectively. Two hundred and fifty-one questionnaire packets were mailed to couples who expressed interest in the study. Each packet contained envelopes with questionnaires for each partner to complete individually. Six packets were returned because of incorrect addresses. Three couples who returned completed questionnaires were ineligible because they had not co-habited for at least 6 months. Of the 480 respondents who were eligible for the study, 210 returned questionnaires, a 44% return rate. This resulted in a total sample of 98 couples, with an additional 14 individuals (10 women and 4 men) who returned their questionnaires but whose partners did not. Because the analyses required data from couples, results will be reported for the couples for whom both partners participated.

Subjects were mailed a consent form (see Appendix C), the Beck Depression Inventory, the Silencing the Self Scale, the Dyadic Adjustment Scale, a self-report version of the self-complexity measure, and a demographic questionnaire (see Appendix D). The total time required per subject should not have exceeded 1 hour. Self-addressed, stamped envelopes were included for returning the questionnaires and consent forms.

Measures

Beck Depression Inventory. The Beck Depression Inventory (BDI; Beck, Rush, Shaw and Emery, 1979) is a 21 item self-report measure of depressive symptoms. Each item contains 4 phrases describing levels of depressive symptoms. Subjects choose the phrase that best describes them. Beck, Steer and Garbin (1988) reviewed several studies on the psychometric properties of the BDI (Beck et al., 1979). Test-retest reliability for the BDI was good, with correlations of .90 after two weeks in nonclinical samples, and correlations of .82 after a month in psychiatric groups (Beck et al., 1988). Low discriminant validity precludes the use of the BDI as a diagnostic instrument, and Beck and colleagues (1988) recommend its use only as a measure of the severity of depressive symptoms. In the present sample, the BDI was internally consistent for both husbands and wives, with alpha coefficients of .88 and .90, respectively.

Revised Dyadic Adjustment Scale. Marital satisfaction was assessed using the Satisfaction subscale of the Revised Dyadic Adjustment Scale (Busby, Christensen, Crane & Larson, 1995). Subjects rated items such as, "How often do you and your partner quarrel?" on a 6-point scale, ranging from "All the Time" to "Never." The original DAS (Spanier, 1976) was the product of a factor analysis, in a non-probability sample, of a lengthy list of items derived from previous measures of marital adjustment. Four factors were derived (Spanier, 1976) and later confirmed (Spanier & Thompson, 1982; Eddy, Heyman & Weiss, 1991): Dyadic Consensus, Dyadic Satisfaction, Dyadic Cohesion, and Affectional Expression. However, some subsequent factor analyses failed to replicate the structure of the original DAS, suggesting that it measured an overall "adjustment" dimension (Sharpley & Cross, 1982), or a single "satisfaction" factor (Kazak, Jarmas & Snitzer, 1988). Other factor analyses concluded that the

Satisfaction subscale of the DAS was not valid (Crane, Busby & Larson, 1991). The debate about the structure and theoretical basis (or lack thereof) of the DAS led some researchers to suggest a new conceptualization of the measure using a hierarchical model in which the four factors load onto a single over-arching factor of "adjustment" (Sabourin, Lussier, Laplante & Wright, 1990).

Busby and his colleagues (1995) revised the scale using a construct hierarchy and validated the new measure in a sample of distressed and non-distressed couples. The RDAS was better than the DAS at classifying non-distressed couples. However, the two measures are highly correlated, and are significantly correlated with other measures of marital adjustment (Busby et al., 1995). The split-half reliability of the RDAS was .95, with the reliability of the three subscales of the measure ranging from .80 to .89. The Satisfaction subscale of the RDAS was selected because it showed greater discriminant validity than the other subscales and had the lowest number of false negatives (16%); the RDAS Satisfaction subscale correctly classified 75% of cases (Busby et al., 1995).

In order to determine how the RDAS Satisfaction subscale compared with the total RDAS and the original DAS, comparisons between RDAS Satisfaction scores, total RDAS scores, and total DAS scores were made using unpublished data from a separate community sample of 130 women. In this sample, the RDAS Satisfaction scale was significantly correlated with the total RDAS ($r = .823$, $p < 0.01$) and with the DAS ($r = .816$, $p < 0.01$). These correlations indicate that the RDAS Satisfaction subscale can be compared to previous studies of marital adjustment and satisfaction. The Satisfaction subscale of the RDAS was internally

consistent for both husbands and wives in the present sample, with alpha coefficients of .85 and .80, respectively.

Silencing the Self Scale. The Silencing the Self Scale (STSS; Jack, 1991) is a self-report measure of over-investment in relationships, as well as putting others' needs before one's own. Subjects rate items such as, "I tend to judge myself by how I think other people see me," on a 5-point scale ranging from "Strongly Disagree" to "Strongly Agree." The STSS has been found to be internally consistent, with an alpha range from .86 to .94 in samples of undergraduates, battered women living in shelters, and cocaine-abusing mothers (Jack & Dill, 1992). The measure has excellent test-retest reliability, with r values of .88 to .93 in various samples (Jack & Dill, 1992). As predicted by Jack's (1991) theory, STSS scores are consistently related to marital dissatisfaction (e.g., Thompson, 1995) and depressive symptoms in diverse samples (e.g., Jack & Dill, 1992). As with the previous measures, the STSS was internally consistent for both husbands and wives in this sample, with alpha coefficients of .85 and .89, respectively.

Self-complexity. A variation of Linville's (1987) trait sort measure of self-complexity was used. The present study used descriptors provided by Setterlund (personal communication, July 21,1995). The 39 descriptors were balanced in terms of positive (e.g., self-assured, creative, generous) and negative (e.g., lazy, irresponsible, manipulative) traits; their selection is described by Neidenthal, Setterlund and Wherry (1992). These adjectives were printed on a sheet containing the instructions for the task, as in Cohen and colleagues (1997). Subjects were instructed to describe themselves using these adjectives by sorting them into categories. They were instructed that any number of groups could be formed using as few or as many of the adjectives as they desired, and that the descriptors could be used more than once. Adjectives in

each group were recorded on a separate sheet, with each category occupying a separate column. Subjects labelled each self-aspect. No data are available on the reliability or validity of Linville's (1987) trait-sort, or on Cohen and colleagues' (1997) self-report version of this task. However, the construct appears to be valid; previous researchers found that individuals with low self-complexity scores report greater reactions to stressful life events than those with higher scores on the self-complexity measure (e.g., Linville, 1985, 1987; Smith & Cohen, 1993).

As in Linville (1985), overall self-complexity was calculated using H:

$$H = \log_2 h - (\sum h_i \log_2 h_i)\, h,$$

where h is the total number of traits, 39 in this case, and h_i is the number of traits appearing in a particular combination of categories.

Smith and Cohen (1993) used a similar method to calculate the proportion of the self-concept occupied by a particular aspect, in this case, the romantic aspect. Using the data from the trait sort, the Relationship Impact Quotient (RIQ) scores were calculated using Smith and Cohen's (1993) equation:

$$\text{RIQ} = \frac{\log_2 h - [\sum(k_i \times \log_2 k_i) + (h - k) \times \log_2(h - k)] / h}{\text{SC}}$$

Again, h is the number of traits. k represents the number of traits in the relationship self-aspect, and k_i is the number of traits in the relationship aspect that appear in specific group combinations. This calculation results in a measure indicating the proportion of the self-image occupied by the relationship aspect, and the independence of this aspect from other self-aspects; thus, the measure can be used to indicate the extent to which individuals defines themselves in

terms of their relationships. Previous research indicates that high RIQ scores predict the severity of reactions to relationship breakup (Smith & Cohen, 1993).

Demographic questionnaire. Demographic variables, such as age, education, employment, and number of children, were recorded on a separate form.

Results

Data Screening

Data were assessed for accuracy of entry and missing values. Couples in which only one partner returned a questionnaire were eliminated from the analysis. Following the elimination of couples in which only one partner returned the questionnaires, subjects' data were checked for individual missing items on questionnaires which were otherwise complete; there were few missing values, and they seemed to be randomly distributed. In cases in which a subject was missing one item on a particular questionnaire, the sample mean for that item was substituted. Subjects who were missing more than one item on a particular questionnaire were removed from the analysis. Several subjects who did not complete the self-complexity measure were also eliminated from the analysis, resulting in a final sample of 85 couples. Next, variables were examined for normality. Skewness and kurtosis values provided by SPSS frequencies, as well as the histograms for the variables to be included in the analysis, were within acceptable limits, with two exceptions. Both husbands' and wives' RDAS Satisfaction scores were negatively skewed and kurtotic. Although negative skewness is commonly seen in the marital satisfaction of community samples, the high values for kurtosis observed here were presumably a result of the small number of items used to assess satisfaction. Following recommendations by Tabachnick and Fidell (1989), the logarithms of reflected values for each variable were used in

the analysis. It should therefore be noted that high values on the transformed variables represent *dissatisfaction* with the marriage. Multicollinearity and singularity were assessed using Pearson coefficients among the variables included in the analyses, which are presented in Table 1.

Characteristics of the sample

Table 2 describes the demographic characteristics of the 85 couples in the sample. The majority of the couples were married (73%), and had lived together for an average of approximately 8 years. Slightly more than half of the couples (57%) had children. Wives' mean socio-economic status rating was comparable to motion picture projectionists, and husbands' mean SES was equivalent to telephone installation workers (Blishen, Carroll & Moore, 1987).

Table 1

Bivariate correlations among husbands' and wives' variables

Measure	1	2	3	4	5	6	7	8	9	10
1 BDI. Wife	--									
2. Trans. RDAS-SS. Wife	.52**	--								
3 STSS. Wife	.45**	.34**	--							
4. SC. Wife	.12	-.02	-.12	--						
5 RIQ. Wife	0	0	-.24*	.36**	--					
6. BDI. Husband	.40**	.34**	.33**	.02	0	--				
7. Trans. RDAS-SS. Husband	.45**	.61**	.25*	-.10	0	.39**	--			
8. STSS. Husband	.14	0	0	.06	.19	.33**	.22*	--		
9. SC. Husband	.20	.07	.11	.33**	.02	.03	.06	-.03	--	
10. RIQ. Husband	0	.10	.10	.07	.35**	.12	0	-.10	.21	--

Notes. BDI = Beck Depression Inventory; Trans. RDAS-SS = Revised Dyadic Adjustment Scale-Satisfaction Subscale. Transformed; STSS = Silencing the Self Scale; SC = Self-Complexity; RIQ = Relationship Impact Quotient.

*$p < .05$ **$p < .01$

Table 2

Means and standard deviations for the demographic and study variables

	Wives		Husbands			
	Mean	**SD**	**Mean**	**SD**	*t*	*p*
Duration of marriage/cohabitation (years)	7.87	9.47	7.87	9.47	-	-
Number of Children[1]	2.23	1.42	2.23	1.42	-	-
Age (years)	34.92	12.40	35.93	11.24	-1.14	.256
Education (years)	15.28	2.18	15.18	2.53	.136	.892
SES[2]	43.02	15.57	50.72	15.08	-2.74	.01
Depressive symptoms (BDI)	7.97	7.71	6.89	6.79	.942	.349
Marital satisfaction (RDAS-Sat)	15.41	2.58	15.31	2.97	.305	.761
Transformed RDAS-Sat	0.6	0.24	0.7	0.21	-4.88	.00
Self-Silencing (STSS)	70.48	17.69	81.93	16.23	-4.53	.00
Self-complexity (SC)	2.61	0.9	2.34	0.88	1.88	.06
Relationship Impact Quotient (RIQ)	0.33	0.2	0.34	0.22	-.46	.65

Note. SES = Socio-economic status; BDI = Beck Depression Inventory; RDAS-Sat = Revised Dyadic Adjustment Scale, Satisfaction Subscale; STSS = Silencing the Self Scale

[1] Calculated for couples with children only. [2] Calculated only for subjects employed outside of the home.

Table 2 also shows the means and standard deviations of the measured variables for the couples included in the path analysis. Mean BDI scores for the husbands and wives were in the non-distressed range; 17% of the husbands and 20% of the wives fell in the "mild mood disturbance" or higher categories, with BDI scores of 11 or more (Beck, Rush, Shaw & Emery, 1979). Satisfaction scores on the RDAS were comparable to those reported previously for non-distressed couples (Busby et al., 1995), with 14% of wives and 13% of husbands reporting satisfaction scores falling one standard deviation or more from Busby and colleague's mean for satisfied couples. Scores on the Silencing the Self Scale were similar to those obtained by Thompson (1995), for both men and women. Self-complexity scores were comparable to those reported by Cohen and colleagues (1997) in an undergraduate sample. RIQ scores in this sample were higher than those obtained for undergraduates (Cohen et al., 1997), as would be expected when comparing married couples to university students.

Paired t-tests (see Table 2), revealed significant differences between husbands and wives on some of the variables being tested. Although there were no significant differences between partners on RDAS Satisfaction, examination of the transformed variables revealed that husbands in the sample were significantly more dissatisfied than were wives. As reported by Thompson (1995) and others, men in the sample engaged in significantly more self-silencing behaviours than did the women. No other significant gender differences were observed in the variables to be entered in the path analysis.

Test of the causal path model

The zero-order correlations among the variables are reported in Table 1. As expected, husbands' and wives' depressive symptoms were significantly correlated with their own marital

dissatisfaction. Self-silencing scores were also related to husbands' and wives' depressive symptomatology. Wives' self-silencing was correlated with husbands' depressive symptoms and marital dissatisfaction. As expected, however, husbands' self-silencing was unrelated to the wives' variables. Contrary to Thompson's (1995) findings, self-silencing was related to marital dissatisfaction for both men and women. Z-tests revealed non-significant differences between husbands and wives on the correlations between depressive symptoms and marital distress (r = .39 and .52, respectively; $z = 1.05$, $p > .10$), between depressive symptoms and self-silencing (r = .33 and .45, respectively; $z = .91$, $p > .10$), and between self-silencing and marital dissatisfaction (r = .22 and .34, respectively; $z = .83$, $p > .10$). Wives' RIQ scores were related only to their own self-silencing and to their husbands' RIQ. Note that the correlation between RIQ and self-silencing in women is in the direction opposite to that predicted by self-silencing theory: women who defined themselves in terms of their marital relationships were less likely to silence their feelings and needs than were other women. Husbands' RIQ scores were correlated only with their wives' RIQ scores. As in previous studies, husbands' depressive symptoms and marital dissatisfaction were correlated with wives' symptoms and dissatisfaction. Self-complexity was unrelated to other variables, with the exception of RIQ scores.

The model shown in Figure 2, hereafter referred to as Model 1a, was tested using the AMOS statistical computer package, using the maximum likelihood estimation technique. Residual variables for all downstream variables in the model had their variances set to 1. The AMOS program provides several statistical measures of the goodness of fit of the model, not all of which will be reported here. The measures of fit chosen in the present study each have established "cut-off"scores which indicate an good fit of the model to the data. The chi square

(_^{2}) is the Likelihood Ratio Test statistic, which postulates that the proposed model is valid, and tests this hypothesis (Byrne, 1998). The higher the probability associated with the _^{2} statistic, the closer the fit between the model and a perfect fit; that is, high p values represent small differences between the hypothesized model and a perfect one. Smaller _^{2} values reflect better fit of the model. This measure of fit is commonly used, and is reported by all computerized causal modeling packages (Byrne, 1998). However, the _^{2} statistic is sensitive to sample size and to deviations from normality. The Goodness of Fit Index (GFI) and Adjusted Goodness of Fit Index (AGFI) were chosen because they are absolute indices of fit. These indices measure the relative amount of variance and covariance in the covariance matrix that is explained by the matrix and compare the model to no model at all (Byrnc, 1998). Both measures are standardized, with values between 0 and 1; Byrne (1998) reported that values close to 1 indicate a good fit. The AGFI takes parsimony into account by including the model's degrees of freedom in its calculation, whereas the GFI does not. The Root Mean Square Error of Approximation (RMSEA) also takes into account the degrees of freedom in the model, and represents the discrepancy between the application of the hypothesized model in the sample and how well the model would fit in the population (Byrne, 1998). RMSEA values also fall between 0 and 1. Values below .05 indicate a very good fit of the model to the population, and values between .05 and .10 indicate a reasonable fit. Finally, the most commonly used index of fit, the CFI, also falls between 0 and 1, and values greater than .90 represent a good fit of the model to the data (Byrne, 1998). The CFI takes sample size into account in its comparison of the fit of the proposed model to the fit of the "independence model," in which all of the variables are uncorrelated.

Testing of Model 1a, using the statistics described above, yielded an acceptable fit of the model to the data (_^{2} = 8.065, p = .327; GFI = .972; AGFI = .915; RMSEA = .043; CFI = .990). Standardized path coefficients are shown in Figure 2. All hypothesized paths were significant and in the expected directions, with two exceptions. It appears that wives' silencing and marital dissatisfaction have overlapping variance in their correlations with depressive symptoms; the inclusion of both variables in the model reduced the associations between each variable and depressive symptoms. Interestingly, the relationship between husbands' depressive symptoms and wives' marital dissatisfaction (see Table 1; r = .34, p < .01) was mediated by the husbands' dissatisfaction with the marriage. Contrary to theory, wives' RIQ scores were negatively related to self-silencing. Also, although husbands' marital dissatisfaction and wives' self-silencing were correlated (see Table 1; r = .25, p < .05), the path between these variables in the causal model was not significant; this relationship was entirely mediated by the path between the husbands' and wives' marital dissatisfaction. An examination of the modification indices did not indicate the inclusion of additional paths in the model.

Tests of alternative models. In order to identify possible gender differences, Model 1a was tested a second time with the partners' variables reversed; that is, husbands' RIQ, STSS, RDAS and BDI scores were used in place of the wives' scores. This model will be referred to as Model 1b (see Figure 3). Once nonsignificant paths were removed, the goodness of fit indices of fit indicated a poor fit of the model to the data. These results indicate that the hypothesized model predicts women's, but not men's depressive symptoms. Table 3 provides a comparison of the _^{2} and RMSEA statistics for the models tested in the present study; these statistics were chosen because they most clearly differentiated between the models tested.

Given the correlational nature of the current study, two additional models were tested in order to examine alternative explanations of the data. Although previous longitudinal path analyses have clarified the relationship between marital dissatisfaction and depressive symptoms, none have included self-silencing or self-complexity in their models. It is possible that married women who experience depressive symptoms might become more focused on their marriages, perhaps as a result of rumination about their difficulties. Thus, it is possible that depressive symptoms could be directly associated with RIQ scores, which, in turn, are related to self-silencing. Model 2a (see Figure 4a) was proposed as a test of this hypothesis. This model did not provide an adequate fit to the data. As with Model 1b, Model 2b represents a test of Model 2a with the partners' variables reversed (see Figure 4b). Again, the model did not fit the data.

Another plausible hypothesis is that women who experience depressive symptoms are more likely to silence their negative feelings within their marriages. Model 3a was proposed as a test of this hypothesis; Figure 5a shows the final model, after non-significant paths were removed. Goodness of fit measures indicate that the model adequately fit the data, although the probability statistic associated with χ^2 approaches significance and the RMSEA value approaches .1. Note that the paths between husbands' depressive symptoms and wives self-silencing, and between wives marital dissatisfaction and their self-silencing, are non-significant in Model 3a, although both relationships were significant in Model 1a. When wives' depressive symptoms were used to predict their self-silencing, their symptoms mediated the relationships between self-silencing and the other variables. Model 3b represents a test of Model 3a with the

partners' variables reversed (see Figure 5b). This model did not fit the data. Overall, although Model 3a provided an adequate fit to the data, Model 1a provided the best fit.

Table 3

Goodness-of-fit statistics for the proposed models

	Model 1a (Figure 2)	**Model 1b (Figure 3)**	**Model 2a (Figure 4a)**	**Model 2b (Figure 4b)**	**Model 3a (Figure 5a)**	**Model 3b (Figure 5b)**
χ^2	8.065	15.95	17.832	20.909	17.348	14.676
(*p*)	(.327)	(.026)	(.013)	(.004)	(.067)	(.023)
RMSEA	.043	.123	.136	.154	.094	.131

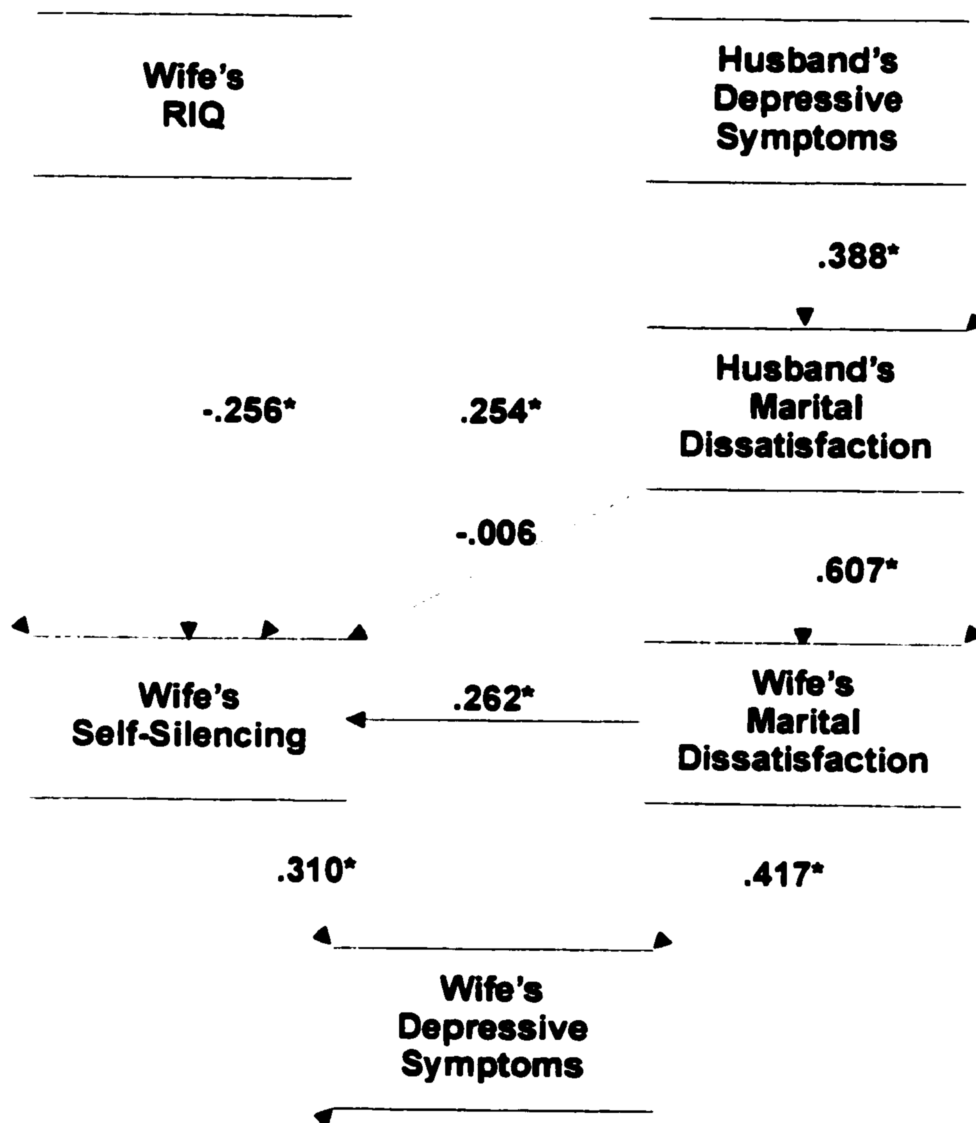

Figure 2: Model 1a, including standardized path coefficients.
*$p < .05$.

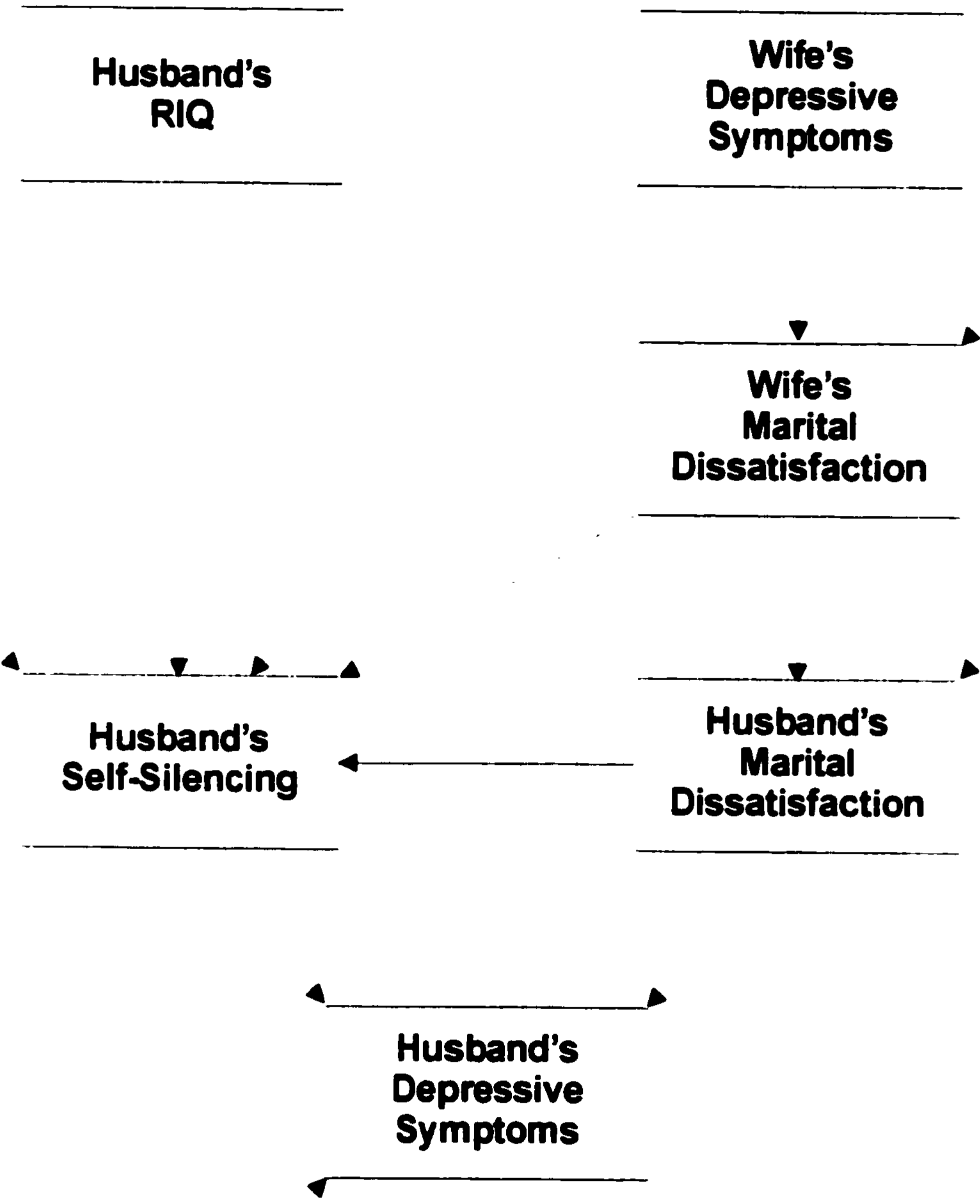

Figure 3: Model 1b, predicting husbands' depressive symptoms in relationships

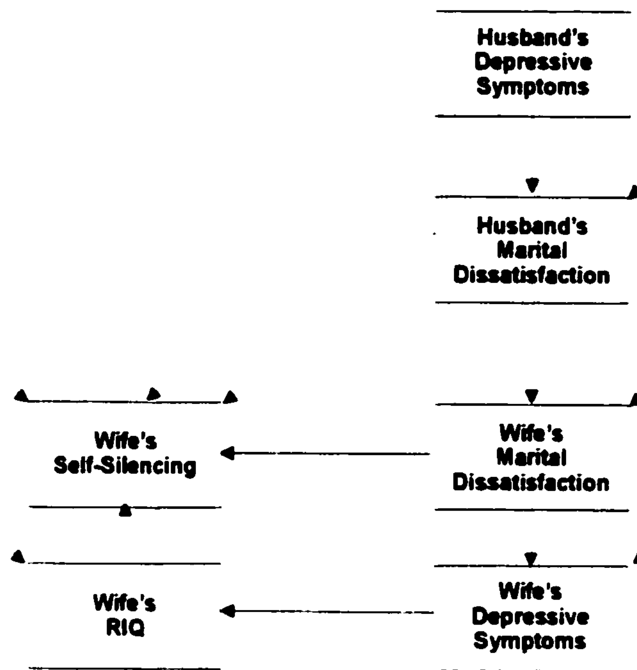

Figure 4: Model 2a, predicting wives' RIQ from wives' depressive symptoms.

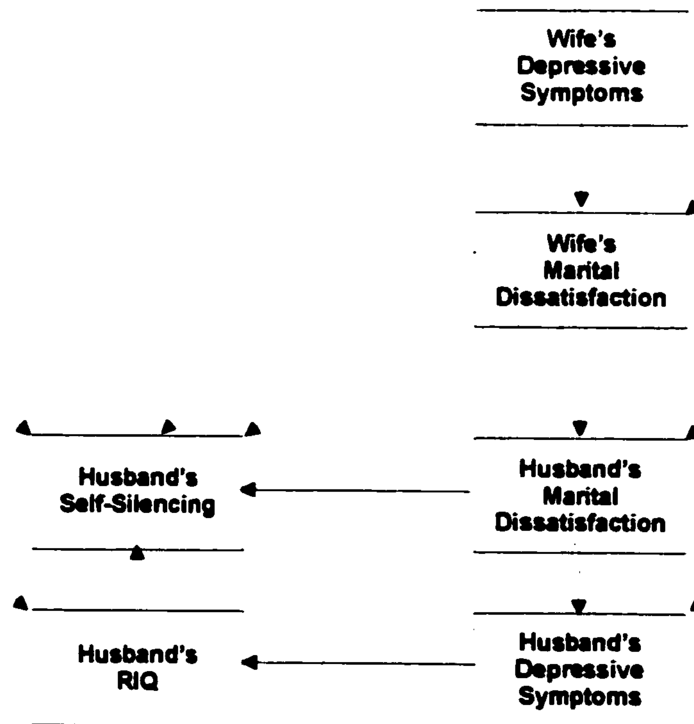

Figure 5: Model 2b, predicting husbands' RIQ using husbands' depressive symptoms.

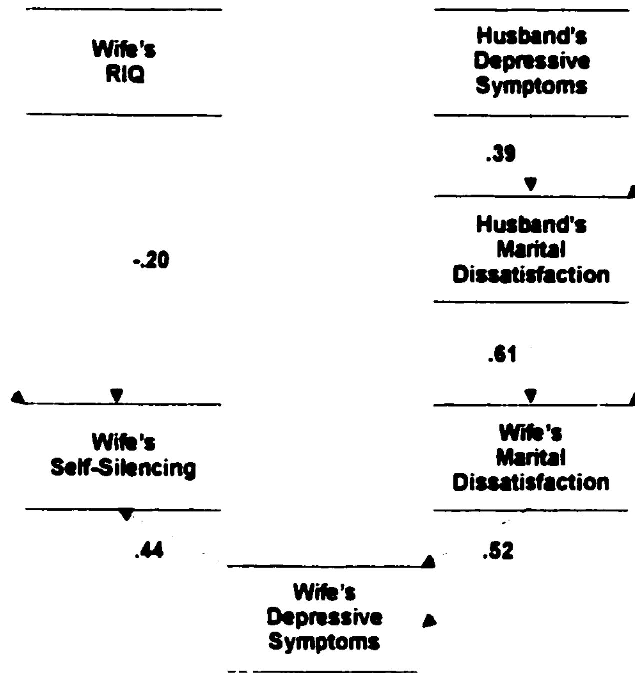

Figure 6: Model 3a, predicting wives' self-silencing from wives' depressive symptoms, with standardized path coefficients.

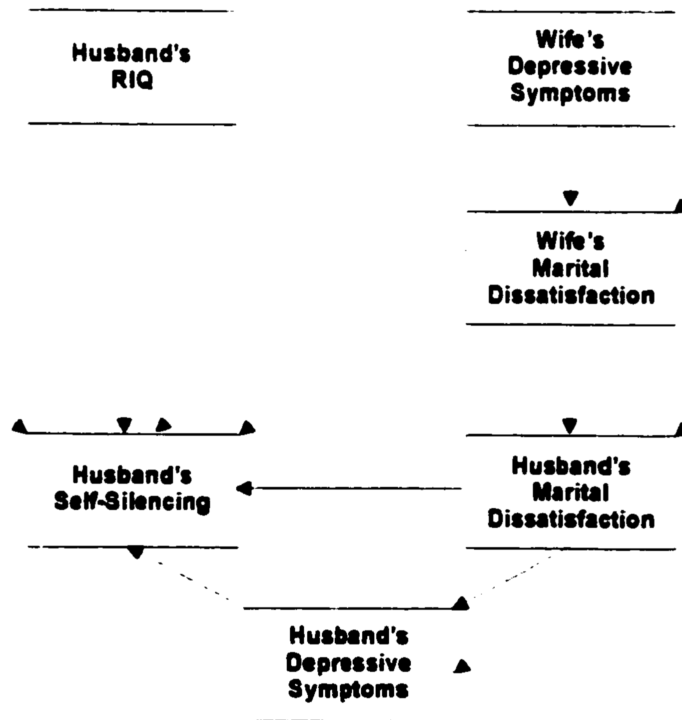

Figure 7: Model 3b, predicting husbands' self-silencing using husbands' depressive symptoms.

Discussion

This study tested a model that was proposed to clarify the relationship between marital dissatisfaction and depression. The model described a "domino effect" in predicting women's, but not men's, depressive symptoms, in which husbands who report depressive symptoms are likely to be dissatisfied with their intimate relationships, which is related to an increase in the likelihood that their wives will also be dissatisfied, which is associated with an increase in the number and severity of wives' depressive symptoms. However, given the low means for depressive symptoms and marital dissatisfaction in the sample examined in the present study, it may not be appropriate to generalize these results to depressed, maritally distressed individuals. It may be suitable to describe low levels of marital dissatisfaction as *protective* against depressive symptoms. That is, husbands who do not report depressive symptoms are more likely to be satisfied with their marriages, which is related to their wives' marital satisfaction, which is associated with fewer depressive symptoms. Nonetheless, the integrative model provided the best fit to the data of the models tested, supporting the hypothesis that wives' depressive symptoms, or lack thereof, are indirectly associated with their husbands' symptoms and marital satisfaction. Although previous causal models have examined gender differences in the depression/marital dissatisfaction relationship (Fincham et al., 1997), none have tested a theory-based model that combined husbands' and wives' depressive symptoms, marital satisfaction, and other variables influencing the relationship into the same model.

The relationships between wives' depressive symptoms and their husbands' variables have an important implication: the data are consistent with the hypothesis that women are at greater risk for developing depression partly because they are vulnerable not only to events in

their own lives, but also to their husbands' depressive symptoms. Men's emotional distress is not associated with their partner's symptoms in the same way. Women's vulnerability to the distress of others has been documented previously (Kessler & McLeod, 1984; Turner & Avison, 1998; Whiffen & Gotlib, 1989). In analyses of data from several epidemiological surveys in the United States, Kessler and McLeod found that women were more vulnerable than men to what the researchers called "network events," or stressors occurring in the lives of significant others. They proposed a "cost of caring" hypothesis to explain gender differences in depression, arguing that the increased involvement of women relative to men in the lives of significant others increased their risk for depression. Whiffen and Gotlib also found women to be vulnerable to depressive symptoms when their partners were having difficulties. In couples with a maritally dissatisfied husband, both partners reported depressive symptoms; when the wife was dissatisfied, only she exhibited depressive symptomatology. As in Kessler and McLeod's and Whiffen and Gotlib's studies, women in the present study whose husbands were experiencing problems (i.e., depressive symptoms) were at greater risk for developing depressive symptoms.

In the present study, self-silencing was hypothesized to represent relationship beliefs and coping mechanisms that would increase the likelihood that women would develop depressive symptoms. The association between self-silencing and depressive symptomatology was expected to be stronger among women than men. This gender difference was not found in the present study. Of the previous studies examining gender differences in the association between self-silencing and depressive symptoms (Gratch et al., 1995; Page et al., 1996; Thompson, 1995), only one used a community sample of married and co-habiting individuals (Thompson, 1995). Although all of these studies reported that men obtained higher self-silencing scores than

did women, only Thompson (1995) found a gender difference in the correlation between self-silencing scores and self-reported depressive symptoms; women's silencing was more closely related to their depressive symptoms than was men's silencing. Such a difference was expected in the present study, given that the data were collected from a sample similar to Thompson's (1995). However, consistent with studies of undergraduates, no gender differences were found in the correlations between self-silencing and depressive symptoms in the present study.

It is difficult to reconcile the findings of the present and previous studies (Gratch et al., 1995; Page et al., 1996) with those of Thompson (1995). The subjects in Thompson's (1995) sample were married, on average, for approximately 15 years. In the present study, couples were married for an average of approximately 8 years. Recall that Thompson and colleagues (in press) found that women's silencing was influenced by their current intimate relationships, whereas men's silencing was related to perceptions of their relationships with their parents as well as with their wives. It is possible that, because women's silencing is related to the present relationship, the association between silencing and depressive symptoms becomes stronger in women as the current relationship progresses. Men's silencing, which is related to their perceptions of their relationships with their parents as well as their marital relationships, may not become more strongly associated with depressive symptoms over the course of the marriage, possibly leading to increasing gender differences in the correlates of self-silencing later in marriage. However, when the correlations between men's and women's self-silencing and depression in the present study were examined while controlling for the duration of their marriages, no gender difference was found. The present study of couples who had generally been married for less than 9 years, as well as studies with unmarried undergraduates, have not

found gender differences in the relationship between self-silencing and depressive symptoms. Further investigation is required to clarify gender differences in the association between marital dissatisfaction and self-silencing. The typical findings, that men silence to a greater extent than do women and that silencing is related to depressive symptoms in both genders, indicate that the role and beliefs measured by the STSS are not specific to women.

Three variables that were expected to be related to self-silencing in women were measured in the present study; of these, two were associated with silencing in the expected direction. First, women were more likely to obtain high silencing scores when they were dissatisfied with their marriages. This association has been previously reported by Thompson (1995), and fits with Jack's (1991) notion that women silence their negative feelings about their intimate relationships. This finding is also consistent with previous research, which has reported that couples in which anger is expressed are more likely to report marital satisfaction later in their relationships (Gottman & Krokoff, 1989). That is, couples in which negative feelings are *not* silenced report greater marital satisfaction over the course of their relationships. Interestingly, women who are compliant are more likely to report concurrent marital satisfaction, but they become more dissatisfied over time (Gottman & Krokoff, 1989). The concurrent marital satisfaction associated with compliance may reinforce silencing. Contrary to Jack's (1991) hypothesis and Thompson's (1995) findings, the relationship between marital dissatisfaction and self-silencing in the present study was not specific to women. When either partner was dissatisfied in the marriage, that partner was more likely to silence his or her negative feelings.

The second variable that was expected to be related to an increase in women's self-silencing was the level of difficulty being experienced by their partners (e.g., depressive symptoms or marital dissatisfaction). Consistent with previous research, husbands' depressive symptoms were associated with their wives' silencing; the significant zero-order correlation between husbands' marital satisfaction and wives' silencing was mediated by the wives' satisfaction. Nurturing is a characteristic associated with the feminine role (Bem, 1974; Spence & Helmreich, 1978), and women are socialized to care for significant others (Jack, 1991). It is possible that wives perceived their husbands' depressive symptoms and put their own needs aside to care for their vulnerable partners. The notion that self-sacrifice is equivalent to caring may be an important factor in explaining wives' silencing in response to husbands' depressive symptoms. Kessler and McLeod (1984) hypothesized that the coping styles used by women to deal with caring for others may be ineffective, thus leading to depression, a theory echoed by Nolen-Hoeksema (1991). Self-silencing may be one example of an ineffective coping style used by women when caring for others.

The final variable that was expected to be related to an increase in women's silencing was when their marital relationship was central to their sense of self. Jack (1991) argued that the central importance of the marital relationship would increase anxiety that the relationship might end, leading to self-silencing to avoid conflict. In the present sample, the reverse was true. When their marital relationship was central to their self-concept, women were less likely to self-silence. This association, which has not been previously tested, flies in the face of self-silencing theory, and needs to be explained. To do so, it may be helpful to turn to the adult attachment literature. Thompson (1995) compared "compliant connectedness," which Jack

(1991) considered to be essential to the development of self-silencing, to an anxious attachment style, in which one becomes worried that the relationship might end. Although attachment styles were not assessed in the present study, it is possible that RIQ, a measure of investment in one's relationships, is related to attachment.

Attachment theory emphasizes the importance of relationships in human development (Bowlby, 1969). Although attachment theory was originally proposed to describe and categorize the relationships of infants and their caregivers, recent researchers have applied attachment theory to adult relationships. Shaver, Hazan, and Bradshaw (1988) argued that patterns of behaviours in and beliefs about romantic relationships can be categorized as *secure* or *insecure*. Insecure attachment styles can be further broken down into anxious or avoidant attachment (Brennan & Shaver, 1995). Some researchers conceptualize adult attachment as encompassing two dimensions: views of the self in relationships and views of others, either of which may be positive or negative. Bartholomew (1990) thus proposed four dimensions of attachment. Securely attached individuals view themselves and others positively. Preoccupied people have negative self-views and view others positively. Dismissing-avoidant individuals view themselves positively and others negatively, whereas fearful-avoidant persons have negative views of themselves and others.

Jack (1999) agreed with Thompson (1995) that self-silencing was related to an anxious/preoccupied attachment style. The anxious attachment pattern arises when a person believes that he or she is not worthy of love, i.e., he or she has a negative self-view, and therefore he or she becomes afraid that important relationships could end at any time. Anxiously attached persons are preoccupied about maintaining relationships. Such an attachment style may

be associated with high RIQ scores; that is, people who are preoccupied with the marital relationship may be more likely to define themselves in terms of that relationship, to the exclusion of other roles. In contrast, low RIQ scores may be associated with an avoidant attachment style. Avoidant individuals tend to avoid closeness in relationships, out of fear that they will be rejected or because they do not believe close relationships to be important; they value independence over closeness. Such individuals would be unlikely to define themselves in terms of the marital relationship.

Although Jack's (1999) model predicted that self-silencing women would be anxiously attached, research on attachment and conflict management styles does not support this hypothesis. Creasey, Kershaw, and Boston (1999) examined the effects of attachment style on conflict management in undergraduates. Striking differences were found in the manner in which anxiously attached and avoidant individuals communicated with their romantic partners. Contrary to Jack's (1991) hypothesis, the anxious attachment style was related to negative conflict escalation ("When we argue, my negative feelings rise quickly"; Creasey et al., 1999) and to negativity ("We attack each other and do not listen to the other's gripes"; Creasey et al., 1999). Anxiously attached individuals also reported that they tended *not* to edit their feelings ("I try to focus on the positive side of the situation"; Creasey et al., 1999). Avoidant individuals managed their negative feelings in a very different manner than did anxiously attached subjects. They tended to withdraw from conflict ("When discussing issues, I remain silent"; Creasey et al., 1999). Avoidant subjects tended not to express negative feelings to their partners ("I tell this person when I'm disappointed"; Creasey et al., 1999), not to communicate over time ("We confide in each other more than in the past"; Creasey et al., 1999), nor to provide feedback

during discussions ("I summarize the person's message to make sure that [sic] point of view is understood"; Creasey et al., 1999).

These results paint a very different picture of self-silencing than the one that Jack (1991) proposed. Anxiously attached individuals appear to be more likely than others to engage in conflict and to express negative emotions within relationships, whereas avoidant individuals appear to be more likely to self-silence. If high RIQ scores are indicative of anxious preoccupation with the marital relationship, and low RIQ scores indicate avoidance of closeness within the marriage, then the negative association between RIQ and self-silencing makes sense. Women with high RIQ scores, who are more likely to be preoccupied about maintaining their relationships, may tend to express negative feelings and to engage in conflict in order to interact with their partners. Women with low RIQ scores, who may have an avoidant attachment style, withdraw from conflict and silence their negative feelings. Although the relationship between RIQ and attachment style has not been assessed, the negative association between RIQ and self-silencing suggests that women who self-silence are doing so not out of anxiety about maintaining their relationship, but out of a lack of investment in the marriage.

Empirical implications

This model of depression and marital dissatisfaction has four main implications for future research, for studies of both depression and self-silencing: (a) the integration of husbands' and wives' depressive symptoms and marital satisfaction, (b) the inclusion of the husbands' emotional distress in models of self-silencing, (c) the influence of relationship centrality on self-silencing in women, and (d) the influence of marital dissatisfaction on self-silencing.

Whisman (1999) reported that, although several disorders are related to marital problems, depression and marital distress are uniquely related in women, whereas for men, marital distress is uniquely associated with dysthymia. Although current theories relating marital satisfaction to depression have considered the inter-dependence of the husbands' and wives' symptoms, researchers are only beginning to include both partners in causal models (e.g., Fincham et al., 1997). The present study examined the association between the depressive symptoms of husbands and wives, and the association between symptoms and marital satisfaction. Results were consistent with previous path analyses that tested the association between marital adjustment and depressive symptoms for men and women. However, future research should test the integrational model longitudinally to verify the temporal nature of the relationship between husbands' and wives' depressive symptoms.

Coyne (1976b) reported that "contagion" of negative emotion can occur within relationships with a depressed spouse. In a later study, Coyne, Kessler, Tal, and colleagues (1987) found that subjects with clinically depressed spouses tended to be distressed and in need of psychological intervention. Subjects whose spouses were previously, but not currently, depressed did not report elevated distress. These findings suggest that depression in one partner leads to an increased risk of psychological distress for the nondepressed spouse. It is unknown at this time whether the relationship between husbands' and wives' symptoms is specific to depression or if other disorders are similarly associated between spouses. Future research on risk factors in women's depression should include measures of their husbands' emotional distress. In the present study, women were more likely to self-silence when their husbands were experiencing depressive symptoms, consistent with Jack's (1991) construct of "care as self-

sacrifice." This relationship also was reported in a previous study (Thompson, 1995). Future research should take into account partners' vulnerabilities in predicting women's self-silencing. If self-silencing occurs when husbands are experiencing difficulties, such as depressive symptoms, then any mental health concern on the part of husbands may increase their wives' risk for developing depressive symptoms. This study examined only depressive symptoms, but other mental health concerns may also influence marital satisfaction and self-silencing.

Although the role of the husband's mental health in self-silencing can be reconciled with Jack's (1999) theory, the notion that silencing is more likely to occur in situations in which the woman is not invested in the relationship flies in the face of Jack's (1991) model. Studies of attachment patterns that are associated with conflict management styles (e.g., Crealey et al., 1999) suggest that self-silencing may occur in different situations than Jack (1991) envisioned. Research on silencing, attachment, and the centrality of relationships to the sense of self will be essential in clarifying the conditions under which self-silencing occurs.

In the present study, a significant path was found from wives' marital dissatisfaction to their self-silencing, but a longitudinal model is required to test the temporal nature of this concurrent relationship. Although Jack (1991) proposed that women who were dissatisfied in their marriages would also be more likely to self-silence, this relationship has not been tested longitudinally. Gottman and Krokoff (1989) reported that disagreement and anger exchanges were predictive of improvement in marital satisfaction over the course of the relationship, whereas withdrawal from interaction was harmful to later marital satisfaction. Thus, self-silencing women, who tend to withdraw from conflict and tend not to express dissatisfaction and anger, would be expected to be less satisfied later in their marriages; this may lead to further

silencing of negative feelings. Jack (1999) believes that marital dissatisfaction and depressive symptoms are reciprocally related, i.e., that silencing leads to marital distress, which leads to further silencing. Future research should examine cross-lagged models of the association between self-silencing and marital dissatisfaction in order to determine the longitudinal nature of their association.

Clinical implications

Clinically, it seems that an assessment of marital satisfaction should be included when treating married women who present with depressive symptoms. Women who are depressed but satisfied in their marriages may be effectively treated individually. However, maritally dissatisfied, depressed women may be better treated in couples therapy, since marital problems are likely to maintain women's depressive symptoms. In addition, because of the relationship between husbands' depressive symptoms and wives' depression, husbands who present with depression may have depressed wives as well. Although such men can be effectively treated individually, it is important to be aware that their partner is likely to be suffering. Clinicians should keep in mind the "domino effect" that was supported in the present study, which may apply to clinical depression: over time, depressed husbands are likely to become dissatisfied with their marriages, which increases the likelihood that their wives will also become dissatisfied, which makes the wives vulnerable to depressive symptoms.

The use of marital therapy in the treatment of clinical depression has been repeatedly shown to reduce depressive symptoms to the same extent as individual cognitive therapy (Beach & O'Leary, 1992; Beach, Smith & Fincham, 1994; Jacobsen, 1984; O'Leary & Beach, 1990). In addition, for couples in which depression was accompanied by marital discord, marital therapy

increased relationship satisfaction (O'Leary & Beach, 1990); the increase in marital satisfaction was maintained up to a year later (O'Leary & Beach, 1990). However, there are caveats to the general assumption that depressed, married women can be treated using marital therapy. Jacobson, Dobson, Fruzzetti, and colleagues (1991) found that in couples who were not maritally distressed, cognitive therapy was more effective than marital therapy for the treatment of depression. In addition, although it was expected that marital therapy would reduce the likelihood of relapse in depression by improving the relationship, Jacobsen, Fruzzetti, Dobson, and colleagues (1993) did not find differences in the relapse rates of subjects who had received marital or individual cognitive therapy a year earlier. Nonetheless, it is apparent that marital therapy can be an effective tool in the treatment of depression in couples.

In the present study, women were more likely to report depressive symptoms when they were dissatisfied with their relationships or when their husbands reported depressive symptomatology. This occurred partly as a result of self-silencing. As Jack (1991) believes, providing women with the opportunity to express needs and feelings may be therapeutic. Teaching effective coping strategies and the expression of feelings and needs within the marital relationship could be important aspects of therapy, and may reduce the risk of future episodes of depression.

Finally, investment in the marital relationship, even to the exclusion of other aspects of the self, may not be a risk factor for the development of depressive symptoms. In fact, such investment may be related to emotional expression and communication that reduce the risk for depression.

Limitations of the present study

Although the present study extended previous research on the associations among depressive symptoms, marital dissatisfaction, and self-silencing, there are also some limitations. The type of data collected, the number of couples involved in the study, and the types of measures used may limit the generalizability of the findings.

The most important limitation of the present study is that cross-sectional data were used to test a longitudinal model. Thus, the causal model tested here, although theoretically derived from previous longitudinal studies, cannot directly test the temporal relationships among depressive symptoms, marital satisfaction, and self-silencing. The model proposed in the present study provided a better fit to the data than the alternative models that were tested, but longitudinal data would provide the most conclusive test of the proposed paths in the present model. Beach and colleagues recommended that the longitudinal influence of depressive symptoms on marital distress, and vice versa, could best be measured with a follow-up period of approximately 18 months (Beach et al., 1999) . The model in the present study could be tested using four data-gathering points. Such a study could measure husbands' depressive symptoms and wives' RIQ scores at Time 1. By collecting data from a sample in which husband's would be more likely to experience depressive symptoms (e.g., recently unemployed men), the "domino effect" could be examined. Other variables in the model could be measured at Time 1 to control for the effects of initial levels of depressive symptomatology, marital dissatisfaction, or self-silencing on later measurements of these variables. At Time 2, which would ideally occur 18 months later, husbands' marital dissatisfaction could be measured. Wives' marital dissatisfaction and self-silencing would be measured at a third point in time, perhaps 24 months

after the initial data collection. Finally, 18 months after Time 3, wives' depressive symptoms could be measured a second time, and the model could be tested, with data having been collected for each stage in the model at different points of time. Unfortunately, although 18 months may be an optimal length of time between data collection, the difficulty of retaining subjects over such a long period of time would necessitate the compression of the data-gathering points; perhaps a 6 to 8 month period between data collection at each stage, resulting in less than 3 years of data gathering, would be a more feasible study.

A second limitation of the present study is that the generalizability of the results reported here is limited due to the small sample size and the fact that the sample were generally non-depressed and not maritally distressed. Causal models require a large number of subjects to be able to reject models that do not fit the data (Loehlin, 1998). Although the model tested in the present study fit the data well, a larger sample would improve the statistical strength of the analyses. Given the low levels of depressive symptoms and marital dissatisfaction in the present study, it may also be more appropriate to discuss the variables as protective factors against women's depression; that is, low levels of self-silencing, low marital dissatisfaction, and low levels of husbands' depressive symptoms are associated with lower levels of depressive symptomatology in married women. A larger sample may increase the likelihood that depressed or maritally distressed individuals would be sampled. The inclusion of a high-risk group for comparison would also provide better information about the fit of the present model in a more depressed, maritally distressed sample. Couples in which husbands were recently unemployed may provide a sample with higher levels of marital distress and depressive symptoms.

Another limitation of the study is that, although subjects were requested to complete their questionnaires individually, it is possible that they worked together to complete them. One way to better ensure that husbands and wives worked separately to complete the package would be to send one questionnaire packet to one partner, and to send the second one only after the first is returned.

Finally, the current study used only self-report measures. Future research should also include observational and diagnostic measures in addition to self-report questionnaires. Diagnoses of depression or dysthymia would be of particular interest, as the symptoms measured by the Beck Depression Inventory may not be specific to depression. More specific diagnostic tools would allow a determination of whether these findings generally apply to various mental health concerns, or if they are unique to depression. Interviews or observational measures of marital interactions and relationship satisfaction may shed light on specific marital difficulties that are associated with self-silencing. In particular, conflict management styles such as withdrawal may be important in predicting self-silencing.

The measure of self-complexity used in the present study may have been particularly problematic. Linville's (1987) conceptualization of self-complexity is somewhat controversial. Showers (1992a; 1992b) found that the valence of descriptors used in particular self-aspects, and to a lesser extent, the importance of those aspects to the subject, were related to the intensity of reactions to negative information. Neither of these factors have been included in previous studies of RIQ. Furthermore, subjects who used only positive or only negative descriptors could receive the same RIQ score, which would be higher than that of subjects who did not include a relationship self-aspect; there is likely to be a great deal of difference between a person who

describes him- or herself in the relationship using only positive descriptors and one who uses only negative terms. Also, because the RIQ score represents a proportion of the overall self-concept, subjects could feel that their relationship is very important and still receive a low RIQ score if other self-aspects used a large number of descriptors. Thus, the RIQ is not a direct measure of relationship importance. In addition to this conceptual controversy, some subjects reported difficulty understanding the instructions for the RIQ measure; several subjects did not complete the measure. Missing RIQ data was the major reason why several couples were removed from the analysis. Previous studies, including one which used a self-report measure of RIQ (Cohen et al., 1997), were done in a lab where an administrator was available to answer participants' questions. Although in the present study, questions could be answered over the telephone, very few subjects took advantage of this option. Future studies should adjust the instructions for this instrument, perhaps piloting various versions of the directions in the community, and choosing the instructions that are rated as being the most clear. A more detailed example of a completed self-complexity form may also have increased the clarity of the measure. Further research is needed to clarify the effects of these limitations on the relationships between RIQ scores, marital dissatisfaction, self-silencing, and depressive symptoms.

Summary

The present study tested a model integrating husbands' and wives' depressive symptoms and marital dissatisfaction with wives' self-complexity and self-silencing in a community sample of couples. Wives' risk for developing depressive symptoms was greater when they silenced their needs and feelings to care for husbands who reported depressive symptoms. The

husbands' depressive symptoms were also associated with an increase in their wives' marital dissatisfaction, although this relationship was entirely mediated by the husbands' marital dissatisfaction. For the wives, self-silencing and marital dissatisfaction were each associated with an increase in depressive symptomatology. Although the wives' self-silencing was related to their husbands' depressive symptoms and, indirectly, to marital satisfaction, husbands' silencing was not correlated with their wives' variables. This finding suggests that women's reasons for self-silencing may differ from men's.

Contrary to theory. women in this sample were less likely to self-silence if they defined themselves in terms of their marital relationship. This finding was explained in terms of a possible relationship between the centrality of the women's marital relationships to their self-image and their attachment style. Previous studies have identified a relationship between attachment style and engagement in or withdrawal from conflict. Individuals who are preoccupied with their romantic relationships are more likely to engage in conflict and to express negative emotions within those relationships, and may therefore be less likely to self-silence. Jack's (1991) theory predicted that women who were preoccupied with relationships would silence their feelings. The model tested in the present study indicates that women's silencing is more likely to occur in situations in which they are not preoccupied with maintaining their marital relationships.

The findings of the present study suggest that models of women's depression should be considered as inter-dependent on their husbands' emotional distress. The present study also replicates previous findings of a gender difference in the relationship between marital distress and depressive symptoms. Clinicians should be aware of the possible advantages of couples'

therapy in the treatment of depression. Promoting effective coping and emotional expression were also suggested as beneficial in the treatment of depression in married women.

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Appendix A

Recruitment advertisement

COUPLES

Researchers at the University of Ottawa are conducting a study of couples' relationships. Participation will be compensated. Call Dr. Whiffen at 562-5800, ext. 4465 for more information.

Appendix B

Recruitment script

My name is ________________________________, and I am a student in psychology at the University of Ottawa, supervised by Dr. Valerie Whiffen. We are conducting research on the effects of personality and relationship problems on mood. You left a message indicating you would be interested in hearing more about our study. Are you still interested in hearing about it?

We are looking for heterosexual couples who have been married or cohabiting for at least 6 months. If you and your partner decide to participate, you and your partner will be sent a set of questionnaires. These questionnaires ask about your relationship, about your mood in the past week, and about how you think of yourself. They should take about an hour to complete. A self-addressed, stamped envelope will be included so you can return the questionnaires. If both you and your partner return the materials, you will be entered in a draw for $100, and in a draw for two movie passes for your participation in the study.

Your participation in the study is completely voluntary, and you can drop out at any time. All your responses will be kept confidential and anonymous.

Do you have any questions? Would you like to participate in the study?

Appendix C

Consent form

Brian MacDonald, B.Sc.
120 University
University of Ottawa
Ottawa, Ontario
K1N 6N5
562-5800, ext. 4465

Valerie Whiffen, Ph.D.
Centre for Psychological Services
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K1N 6N5
562-5800, ext. 4811

Brian MacDonald, a Ph.D. student supervised by Dr. Valerie Whiffen at the University of Ottawa, is conducting a study on personality, marital problems, and mood. This sheet is intended to provide information about the study, and to inform participants of their rights as research subjects. Consent is required before participating in the study. Your participation in this project is completely voluntary. If you decide to participate, you can withdraw at any time without penalty. If you would like to participate, please sign two copies of this form. One copy is for you to keep for your records, the other is for the researchers.

As we explained on the phone, you will also be asked to complete some questionnaires, which are described below. This should take between 45 minutes and an hour.

Here is a brief description of some of the things you will be asked about:

1. BDI: Your mood in the past week.
2. DAS: Your satisfaction with your relationship with your spouse or partner.
3. STSS: How you act in relationships.
4. SC: How you think about yourself.
5. RSQ: How you feel about relationships.
6. Miller: How you behave in your relationship with your spouse or partner.
7. LEE: How your spouse or partner acts in your relationship.
8. Demographic: Your age, income, number of children, etc.

All the information you provide will be completely confidential. Your name will not appear on any of the questionnaires. We give your answers a number, and only the researcher, Dr. Whiffen, and the research assistant will have access to your number-coded answers. Your name will not be disclosed nor will you be identified in connection with the results of the study. You may withdraw from the study at any time, or refuse to complete any part of it without penalty.

If you have any questions or concerns during the study, please do not hesitate to call 562-5800, extension 4465. Thank you for your time and co-operation.

I, ______________________________, agree to participate in the study that is described above.

Date: ______________________________

Signature: ______________________________

If you wish to receive a written summary of the results of the study, please indicate by providing your name and address below. Please note that we cannot provide you with feedback about your individual responses, but we will supply a description of the major goals and findings of the study.

Name: ______________________________

Address: ______________________________

____

____

Appendix D

Measures

Date: ____________

Name: ______________________ Marital Status: ________ Age: ______ Sex: ______

Occupation: ______________________ Education: ______________________

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2 or 3) next to the one statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1
- 0 I do not feel sad.
- 1 I feel sad.
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad or unhappy that I can't stand it.

2
- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel that the future is hopeless and that things cannot improve.

3
- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4
- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

5
- 0 I don't feel particularly guilty.
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7
- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

8
- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.

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

10
- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now.
- 3 I used to be able to cry, but now I can't cry even though I want to.

11
- 0 I am no more irritated now than I ever am.
- 1 I get annoyed or irritated more easily than I used to.
- 2 I feel irritated all the time now.
- 3 I don't get irritated at all by the things that used to irritate me.

12
- 0 I have not lost interest in other people.
- 1 I am less interested in other people than I used to be.
- 2 I have lost most of my interest in other people.
- 3 I have lost all of my interest in other people.

13
- 0 I make decisions about as well as I ever could.
- 1 I put off making decisions more than I used to.
- 2 I have greater difficulty in making decisions than before.
- 3 I can't make decisions at all anymore.

______ Subtotal Page 1

CONTINUED ON BACK

THE PSYCHOLOGICAL CORPORATION
HARCOURT BRACE JOVANOVICH, INC.

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14
- 0 I don't feel I look any worse than I used to.
- 1 I am worried that I am looking old or unattractive.
- 2 I feel that there are permanent changes in my appearance that make me look unattractive.
- 3 I believe that I look ugly.

15
- 0 I can work about as well as before.
- 1 It takes an extra effort to get started at doing something.
- 2 I have to push myself very hard to do anything.
- 3 I can't do any work at all.

16
- 0 I can sleep as well as usual.
- 1 I don't sleep as well as I used to.
- 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
- 3 I wake up several hours earlier than I used to and cannot get back to sleep.

17
- 0 I don't get more tired than usual.
- 1 I get tired more easily than I used to.
- 2 I get tired from doing almost anything.
- 3 I am too tired to do anything.

18
- 0 My appetite is no worse than usual.
- 1 My appetite is not as good as it used to be.
- 2 My appetite is much worse now.
- 3 I have no appetite at all anymore.

19
- 0 I haven't lost much weight, if any, lately.
- 1 I have lost more than 5 pounds.
- 2 I have lost more than 10 pounds.
- 3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes ______ No ______

20
- 0 I am no more worried about my health than usual.
- 1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
- 2 I am very worried about physical problems and it's hard to think of much else.
- 3 I am so worried about my physical problems that I cannot think about anything else.

21
- 0 I have not noticed any recent change in my interest in sex.
- 1 I am less interested in sex than I used to be.
- 2 I am much less interested in sex now.
- 3 I have lost interest in sex completely.

______ Subtotal Page 2

______ Subtotal Page 1

______ Total Score

THE SILENCING THE SELF SCALE

. APPENDIX B .

Please circle the number that best describes how you feel about each of the statements listed below.

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 they will cause disagreement.
1 2 3 4 5

3. Caring means putting the other person's needs in front of my own.
1 2 3 4 5

4. Considering my needs to be as important as those of the people I love is selfish.
1 2 3 4 5

5. I find it is harder to be myself when I am in a close relationship than when I am on my own.
1 2 3 4 5

6. I tend to judge myself by how I think other people see me.
1 2 3 4 5

7. I feel dissatisfied with myself because I should be able to do all the things people are supposed to be able to do these days.
1 2 3 4 5

*8. When my partner's needs and feelings conflict with my own, I always state mine clearly.
1 2 3 4 5

9. In a close relationship, my responsibility is to make the other person happy.
1 2 3 4 5

10. Caring means choosing to do what the other person wants, even when I want to do something different.
1 2 3 4 5

*11. In order to feel good about myself, I need to feel independent and self-sufficient.
1 2 3 4 5

12. One of the worst things I can do is to be selfish.
1 2 3 4 5

13. I feel I have to act in a certain way to please my partner.
1 2 3 4 5

14. Instead of risking confrontations in close relationships, I would rather not rock the boat.
1 2 3 4 5

*15. I speak my feelings with my partner, even when it leads to problems or disagreements.
1 2 3 4 5

16. Often I look happy enough on the outside, but inwardly I feel angry and rebellious.
1 2 3 4 5

17. In order for my partner to love me, I cannot reveal certain things about myself to him/her.
1 2 3 4 5

18. When my partner's needs or opinions conflict with mine, rather than asserting my own point of view I usually end up agreeing with him/her.
1 2 3 4 5

19. When I am in a close relationship I lose my sense of who I am.
1 2 3 4 5

20. When it looks as though certain of my needs can't be met in a relationship, I usually realize that they weren't very important anyway.
1 2 3 4 5

*21. My partner loves and appreciates me for who I am.
1 2 3 4 5

22. Doing things just for myself is selfish.
1 2 3 4 5

23. When I make decisions, other people's thoughts and opinions influence me more than my own thoughts and opinions.
1 2 3 4 5

24. I rarely express my anger at those close to me.
1 2 3 4 5

25. I feel that my partner does not know my real self.
1 2 3 4 5

26. I think it's better to keep my feelings to myself when they do conflict with my partner's.
1 2 3 4 5

27. I often feel responsible for other people's feelings.
1 2 3 4 5

28. I find it hard to know what I think and feel because I spend a lot of time thinking about how other people are feeling.
1 2 3 4 5

29. In a close relationship I don't usually care what we do, as long as the other person is happy.
1 2 3 4 5

30. I try to bury my feelings when I think they will cause trouble in my close relationship(s).
1 2 3 4 5

31. I never seem to measure up to the standards I set for myself.
1 2 3 4 5

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

*Items with an asterisk are reverse-scored.

Revised Dyadic Adjustment Scale (RDAS)
Satisfaction Subscale

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list. (Please make a checkmark to indicate your answer).

	All the time	Most of the time	More often than not	Occa-sionally	Rarely	Never
1. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	____	____	____	____	____	____
2. Do you ever regret that you married (or lived together)?	____	____	____	____	____	____
3. How often do you and your partner quarrel?	____	____	____	____	____	____
4. How often do you and your mate "get on each others' nerves"?	____	____	____	____	____	____

Self-Complexity (SC)

We are interested in how you describe yourself. Below is a list of 39 traits or characteristics. Your task is to form groups of traits that go together, where each group of traits describes an aspect of you or your life. Form as many or as few groups as you desire. Continue forming groups until you feel that you have formed the important ones. When you feel you are straining to form more groups, it is probably a good time to stop.

The sheet with the columns is your recording sheet. Each column will represent one of your groups. Name the group. then write the names and numbers of the traits you wish to include in that group. Remember that you can use each trait as often as you wish, and you do not have to use all of the traits. The order of the groups and the traits are not important.

Here is a short example of a completed recording sheet. Your groups may be completely different from these ones.

CREATIVE	ALONE	WITH HUSBAND	REAL-WORLD SURVIVAL	BAD TRAITS
14. Industrious 13. Individualistic 11. Humorous	26. Relaxed 30. Serious 17. Lazy	26. Relaxed 25. Playful 29. Sensitive 8. Fulfilled 11. Humorous	23. Outgoing 2. Assertive 20. Mature 5. Disciplined	17. Lazy 16. Irresponsible 39. Unorganized 36. Superficial

Here is the list of characteristics:

1. Anxious
2. Assertive
3. Conformist
4. Creative
5. Disciplined
6. Dishonest
7. Dissatisfied
8. Fulfilled
9. Generous
10. Genuine
11. Humorous
12. In a Rut
13. Individualistic
14. Industrious
15. Insecure
16. Irresponsible
17. Lazy
18. Lonely
19. Manipulative
20. Mature
21. Moody
22. Offensive
23. Outgoing
24. Passive
25. Playful
26. Relaxed
27. Self-Assured
28. Selfish
29. Sensitive
30. Serious
31. Sexy
32. Sophisticated
33. Spontaneous
34. Stable
35. Straightforward
36. Superficial
37. Unattractive
38. Unimaginative
39. Unorganized

Recording Sheet for self complexity

Name of Group:			
Name of Group:			
Name of Group:			

Demographic Questionnaire

Sex: M / F

Age: ____________

How far did you go in school? ____

Are you employed? Y / N

If yes, what is your occupation? ____

Are you Married Living Together (Circle one)

How long have you been married / living together? ___________

Do you have children? Y N

If yes, how many? ______________________________