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Silencing the Self, Relationship Satisfaction and Marianismo

An Analysis of Depression of Latinas

by

Maria D. Vazquez

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

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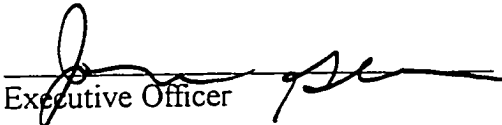
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This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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ABSTRACT

Silencing the Self, Relationship Satisfaction and Marianismo An Analysis of Depression in Latinas

Advisor: Professor Vera Paster

Epidemiological studies have documented that depression is the leading mental health problem for women with rates reported to be twice that of men and some studies indicating a ratio of 3 to 1. Hispanic women are no exception to the rule, and in fact may be at a higher risk because as a group they are more likely to have a preponderance of risk factors.

Contemporary advances in the psychology of women have elucidated how cultural forces interact with adult women's development to create a vulnerability to depression. *Silencing the Self* theory explains women's vulnerability to depression as related to women's belief about intimacy. Women self-silence and self-sacrifice in order to maintain intimacy and in the process experience a loss of authentic connection with the self.

Feminist scholars have linked depression to the repression of anger, low self esteem and feelings of helplessness. In addition, traditional sex roles have been linked to depression. Marianismo, a cultural concept that informs behaviors of Latinas, encourages passivity, self-sacrifice and the repression of anger.

The objectives of the study were: to investigate the relationship of adherence to traditional marianismo sex roles to self-silencing/self-sacrificing behaviors and also to depression for Latina women; to investigate the correlation between relationship satisfaction and depression; to investigate the relationship between traditional sex roles and education.

The main finding of this study is that regardless of age and marital status, women who either did not have a satisfactory relationship, and/or self-silenced and self-sacrificed in the

context of an intimate relationship show consistently higher levels of depression. The implication of the finding is that women's inherent relational orientation may put them at risk for depression.

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TABLE OF CONTENTS

CHAPTER 1.	Overview and Statement of the Problem.....	1
	Objectives.....	4
	Hypotheses.....	4
CHAPTER 2.	Contemporary Research on Hispanic Women and Mental Health.....	5
	Demographic Overview.....	6
	Gender Roles and the Latino Cultural Context.....	7
	Review of Gender Role Research with Latinas.....	10
	Depression and Latina Women.....	15
	Theoretical Frameworks of Depression.....	19
	Application of Theoretical Frameworks of Depression to Latinas.....	29
	Summary.....	33
CHAPTER 3.	Methodology.....	35
	Subjects.....	35
	Instruments.....	38
	Procedures.....	40
CHAPTER 4.	Results.....	42
CHAPTER 5.	Discussion.....	55
APPENDIX A.....		71

APPENDIX B	73
APPENDIX C	74
APPENDIX D	83
APPENDIX E	87
APPENDIX F	96
REFERENCES	98

Chapter 1

Overview and Statement of the Problem

Epidemiological studies have documented that depression is the leading mental health problem for women with rates reported to be twice that of men and with some studies indicating a ratio of 3:1 (Klerman & Weissman, 1989; McGrath, Keita, Strickland & Russo, 1990). The National Comorbidity study by Kessler et al. (1994) not only found that women as compared to men had 2 to 1 rate of depression, but that Hispanics were the highest reporters of depression, while African Americans were the lowest reporters. This interesting finding suggests that Hispanics may suffer disproportionately from depression as compared to other ethnic groups. Although further cross cultural studies are needed in order to investigate the high rates of reporting, what is clear is that Hispanic women are in great jeopardy of suffering from depression because they are more likely to have a preponderance of risk factors associated with the illness (McGrath et al., 1990). These findings are relevant given that Hispanics are one of the fastest growing ethnic groups. By the year 2010 the Hispanic female will represent 11% of the total US population (Hodgkinson, 1992, as reported by Gil, 1996). This rapid growth reflects the Hispanic population's younger age, higher fertility rates and the continuous migration from the Caribbean, Mexico and Latin America (Amaro & Russo 1987). The risk factors associated with depression are racial and ethnic discrimination, lower educational and income levels, unemployment, poor health, larger families, marital dissolution and single families (McGrath, et. al 1990). Canino (1982) points out that all of these factors make Hispanic women vulnerable to mental illness. For the Hispanic women, there is the additional stress of migration and acculturation.

More is known about the diagnosis, treatment and recovery from depression than the etiology of the illness (McGrath et al., 1990). However, recent advances in the psychology of women have gone a long way to explain how cultural forces interact with adult women's development to create a vulnerability to depression. Most of the work in this area has related to mainstream US women. Concurrent with this development there has been a growing literature on the psychology of Hispanic women (Amaro & Russo, 1987). The present research hopes to apply some of the theory and research of adult women's psychological development to Hispanic women in order to understand whether factors that influence depression in US mainstream women also account for depression in Hispanic women.

Jack (1987, 1991) recently advanced a theory to explain women's vulnerability to depression that incorporates ideas from women's moral development, attachment and Self- In-Relation theories. This theory proposes that women tend to silence themselves in order to maintain intimacy and that it is this loss of self that makes women vulnerable to depression. To test her hypothesis the author developed the *Silencing the Self Scale* (STSS) that measures beliefs and behaviors about intimacy (Jack, 1991). Preliminary studies report that there is significant correlation with the *Beck Depression Inventory* (BDI), indicating that the scale is tapping into depression.

Studies conducted with Puerto Ricans and Mexicans reported that gender differences are evident in the rates of depression (Canino et al. 1987; Salgado de Snyder, 1987), where women report higher rates irrespective of class and education. Within the Hispanic culture, *marianismo*, which is based on the cult of the Virgin Mary, is the organizing experience in women's socialization. This learning emphasizes virginity before

marriage and a constellation of behaviors that lead to self- denial, and self- silencing and self- sacrificing behaviors.

While there are many contributing factors to depression, this study will focus specifically on how self-silencing and self-sacrificing behaviors and relationship satisfaction contribute to depression in Latina women. The present study will correlate a measure of silencing the self with the Beck Depression Inventory for a Latina women drawn from a mental health clinic and a community center. It will investigate the relationship between adherence to traditional sex roles, and self- silencing behaviors and depression, where traditional sex roles will be measured by the Inventory of Attitude Towards Men and Women scale. It will also investigate the relationship between satisfaction within an intimate relationship and levels of depression. This is important so that mental health professionals and policy makers may better serve the Latina women. It also will help assess whether the tools and conceptualizations developed in feminist women psychology apply to this group of women. Thus, it will enable the design of mental health programs that are both culturally sensitive and relevant.

OBJECTIVES

This study proposes to assess the construct of self-silencing within intimate relationships among Latina women representative of both a Clinic sample and Community sample. It also proposes to investigate the relationship of adherence to traditional sex roles to self-silencing/self-sacrificing behaviors, and also to depression for Latina women from both Clinic and Community samples. Finally, it will look at how satisfaction within a relationship is related to depression. It is important to understand those factors that may place Latinas at risk for depression. The present study hopes to fulfill this need.

HYPOTHESES

Hypothesis #1

There will be a significant positive correlation between the occurrence of belief in the traditional marianismo sex roles and depression among Latina women.

Hypothesis # 2

Women who report lower levels of relationship satisfaction will have higher levels of depression, regardless of their belief in traditional marianismo sex roles.

Hypothesis #3

The amount of education of Latina women will be negatively correlated with their beliefs in traditional marianismo sex roles for women, regardless of their level of depression.

Chapter 2

Contemporary Research on Hispanic Women and Mental Health

The following section will provide a brief demographic profile of the Latino community that frames the necessity for the continuing research in this area. It is followed by an analysis of Puerto Rican culture with emphasis on the typical patterns evident in gender roles. This is followed by a review of the empirical research of Latinas' perception of sex roles. Most of this research has been conducted with Puerto Rican women, but where possible, relevant research based on other Latino groups will also be presented. This is especially important given the APA task force (McGrath, et al., 1990) finding that a too "feminine" style of personality has been associated with depression. Finally, this section ends with a distillation of the empirical research that addresses the issue of depression in Latino communities. The second part of this chapter opens by elucidating Freud's basic theory of depression since it was one of the first clinical manifestations that he studied. More importantly, his work gradually led towards informing a psychodynamic understanding of this illnesses. It is this understanding that was the foundation for a psychology of women. In this vein, the psychology of migration and its effects upon Latinas is discussed. The seminal work of Carol Gilligan illuminates women's development and the quandary that women experience when the care of self conflicts with the care for others. Paralleling Gilligan's work, the work of clinicians from the Stone Center is presented illustrating the themes that guide women's development. The formulations and empirical research by Dana Jack Crowley, which builds upon Gilligan's work, is presented. This work explores the connection between silencing of the self and depression. Finally, the application of relevant theoretical frameworks presented is applied to the cultural

context of Latina women.

It should be noted that there is no consensus about the naming of the ethnic group of focus whether it be “Latino” or “Hispanic”. Either term is a designation that is not normally used by the people it is intended to describe. A Dominican woman will not say that she is Hispanic or Latina but identifies herself as Dominican. The same could be said of persons from other Hispanic countries. However, these terms have their purpose, and at the moment, Latino appears to be gaining favor in the more recent literature. In this study both terms will be used interchangeably, and in most cases, when presenting secondary sources, the terminology originally used by the author will be respected.

Demographic Overview

In the last decade there has been unprecedented growth in the research of Hispanic women and mental health. The Hispanic population is diverse, subsuming members from twenty countries. Gil (1996) reports from the March 1993 Current Population Report that 64.3% of Hispanics living in the US mainland are Mexican, 10.6% are Puerto Rican, 4.7% are Cuban and 20.4% come from Central and South American. Amaro and Russo (1987) report similar numbers to Gil for the same categories; and emphasize that the relatively younger age of the Hispanic population, compared to the larger population, and its higher fertility rate, along with continuous immigration are the factors that make for the rapid growth of this group. In New York City Dominicans are a large immigrant group comprising 7% of the city’s population (Dugger, 1997). These demographic facts alone are sufficient to make this a compelling area of study.

Gender Roles and the Latino Cultural Context

It has been argued that the countries comprising Latin America are as different from one another as the countries of Europe. The differences are due to a multiplicity of social, political, economic, geographical and historical factors. In addition, a large proportion of the difference is due to the actual presence or legacy of the indigenous population. Despite this diversity, there are several salient features of similarities among Hispanics. Among the commonalities that bind these diverse people are a legacy of Spanish colonial rule, Roman Law and the preeminence of the Catholic religion (Gil, 1996). Other similarities are “a common language, Spanish, along with a cultural values orientation and a traditional pattern of family structure. Traditional men’s behaviors are characterized by *machismo*, in which the man is the authoritarian figure who proves his virility through the domination and impregnation of women. Women’s behavior is characterized by *marianismo*, in which a woman is expected to be submissive, self-sacrificing, dependent, sexually naïve and repressed, and a good housewife,” (Gil, 1995, p.148).

The term *marianismo* was originally described by Stevens (1973) based on her observation of the women of Latin America. The term is derived from the Catholic worship of the Virgin Mary and it aptly identifies the paradoxical thinking of many Latinas, who believe that since women are spiritually superior to men, they are, therefore, capable of enduring all sort of abuse and suffering inflicted by men. They are also expected to remain virgins until they are married being the responsibility of the fathers and brothers to see that this expectation is fulfilled. A martyr complex dictates that the female must accept and adjust to her partner’s macho behaviors, and be self-sacrificing in favor of the children and family (Comas-Diaz, 1987; Vazquez & Gil, 1996). In fact, the values of selflessness

and a sacrificial stance are so encouraged that women are expected to derive fulfillment by placing other's needs above their own. The net effect is that socialization of women as daughter, wife and mother rewards behaviors of passivity, self-sacrifice and abnegation (Margarida-Julia, 1989). But since the mix of gender and role is more complicated in day to day life, Comas-Diaz (1987) observes that women derive power from their roles as mothers, a role that is already imbued with sacredness. As a result, women seek power by forming an alliance with the adult children against the men.

There has not been any systematic psychological study of marianismo. However, Vazquez & Gil (1996) provide the first exposition of the how marianismo is linked to issues of self esteem in Latinas. The authors provide a list of ten commandments that describe the behaviors of a good marianista a woman and note that these proscriptions may interfere with the process of acculturation and affect self esteem.

Bracero (1998) traces the genealogy of marianismo, to early Christianity and Stoic philosophy of the Roman Empire. The ideals of Stoicism, of self-control, self-resignation overlap with marianismo ideals. Bracero notes that marianismo involves disconnection.

While these descriptions may sound static and in the proportion of a Greek tragedy, it does not mean to imply that gender roles are not evolving in Latino communities both in mainland US and in Latin America. The feminist movement has influenced traditional values. Nevertheless, it has been this author's clinical experience that both women and men struggle with the pull of the simulacrum of their sex roles. The pull of these organizing tendencies is evident in the fabric of Latino family life. Family life keeps the basic shapes of the traditional patterns of gender roles in place.

Such is the importance of extended family among Latinos that researchers ascribed the term of *familism* to capture this concept (Comas-Diaz, 1987). It is a culture-specific constellation of values that gives overriding importance to the collective needs of members of a family as opposed to individual or personal needs. It encourages strong identification with and attachment to family members. It promotes strong feelings of loyalty, reciprocity and solidarity among family members. This orientation towards extended family provides economic, emotional and social supports even well after adult children move on to establish their own families. Margarida-Julia (1989) points out that “family orientation is sustained largely through the ideology of the ‘theory of sacrifice’ in which a good woman is defined by her self -abnegation and by placing the family and community needs before her own. Women’s selflessness and sacrifice are crucial in order to assure the continuity of care, responsibility, and the reciprocity of family obligations and ties among generations as parents grow older” (p.119).

Despite the differentiated gender role, there are culturally acceptable modes of expression of other behaviors that deviate from the circumscribed marianista role. For example, for Puerto Rican women the concept of *hembrismo*, which literally means femaleness, provides such an outlet. The term draws upon the historical roots of the Taino Indians, the island indigenous people, who were a matriarchal society. It is further overlaid by the experience of slavery. The term denotes strength derived from adversity; “Black women doubly oppressed by race and gender needed strength and flexibility to adapt” (Comas-Diaz, 1986, p. 464). *Hembrismo* refers to the strength and perseverance of women and in essence denotes a supra-female. Perhaps this is why Christensen (1975) observed Puerto Rican woman as vibrant, ambitious and able to adapt to stressful

situation. He notes that Puerto Rican women are torn between the traditional role while at the same time they are embracing higher education. This is in contrast to Puerto Rican males who seem to see less value in higher education. However, there has not been any empirical findings known to this writer that substantiate these observations.

Review of Gender Role Research with Latinas

Russo (1987) states, “gender must be conceptualized as a dynamic construct that itself varies across ethnic groups and social classes and works in complex interaction with other psychological and social factors”. Taking that into account Vazquez- Nuttal, Garcia and DeLeon, (1987) provide a comprehensive review of the research in this area. The authors point out that the early research of Hispanic families involved subjective descriptions of sex roles even though these studies did not have gender differences as the focus of their inquiry (Vazquez-Nuttal, Romero-Garcia and De Leon, 1987). Two early studies bear mentioning because they tell of the recent legacy of sex roles prior to the feminist movement. One study conducted with Puerto Ricans found that women’s roles varied greatly with the subculture. In rural coffee growing plantations, women’s status and position was based on the husband’s status. A women’s primary function was to raise the children and serve her husband. In contrast, when the professional and business classes were examined, it was found that women were free to avail themselves of educational and occupational opportunities (Steward, 1956).

In another important work, Stycos (1955) looked at family and fertility patterns; he divided low income families into three categories: (a) traditional, (b) less traditional and (c) least traditional. In the traditional home, wives had virtually no decision-making authority. The woman’s primary responsibilities were to the care of her children and

husband. In the less traditional group, the wife shared somewhat in the family decision-making. In the least traditional group, some women worked outside the homes and in a few cases the women were sole wage earners due to husbands' unemployment. Stycos did not find differences among the husbands but did find differences among the women. The better educated women were in the least traditional group. These findings suggest that the catalyst for change in sex roles rested with the women and with social conditions.

Twenty years later studies shifted from the subjective and descriptive to the empirical, and several of these studies of sex roles and power challenged the concepts of rigidly defined gender roles. Cromwell and Ruiz (1979) studied decision making among mainland Chicano families. They did not find evidence to support the myth of male dominance and suggested that the concept of machismo may be more an idealized myth than a reality. However, it is likely that the sample was not high in traditionalism because gender roles tend to be affected by exposure to mainstream Anglo-American values. Clearly, modernization, increased industrialization and a worldwide feminist movement have challenged rigidly prescribed gender roles since Stevens first wrote about *marianismo*. In fact, Vazquez-Nuttall et al.(1987) point out that in the psychological literature the three main explanations for changes in sex roles are acculturation, education, and employment. These variables also often affect depression among Latina women. A discussion of that will follow; however, first a look at how acculturation, education and employment affect sex roles among Hispanic women.

Acculturation

Torres- Matrullo (1975) examined the effects of acculturation on psychopathology among Puerto Rican women. She hypothesized that the greatest conflict and problems of

personal adjustment will be found among the least acculturated. These findings bore out her hypothesis: there was a significant negative correlation found between levels of acculturation and psychopathology. In a later study, she looked at the effects of sex roles on acculturation, also among Puerto Rican women. Her finding indicated that increased contact with Anglo-American society brings changes in sex roles from a traditional, autocratic, male dominated model to a more egalitarian model. Furthermore, she found that increased educational levels also affected attitudes about sex roles. Kranau, Green and Valencia (1982) examined a sample of mostly Mexican American but also other Hispanic women from a college and a factory population, and they found that more highly acculturated women were likely to have more liberal attitudes than less acculturated women. Espin (1982) looked at the age, number of years in the US, the mother's educational level, the participants' fluency in English and the participants' position in the family among thirty one Cuban college females, and found that women who had fluency in both languages appeared to have more liberal attitudes than those with less fluency in English. While proficiency in second language alone is not a definitive measure of acculturation it is a good indication. Canino (1982) looked at sex roles and acculturation by comparing the differing attitudes among 1st generation US born Puerto Rican female adolescents, island female Puerto Ricans, and dominant-culture non-Hispanic Catholic female adolescents. The first group was found to be more liberal than the island Puerto Rican adolescents yet more conservative than the dominant-culture Catholic adolescent girls. In sum, while there may be a lack of consensus about how acculturation is measured, these studies point out that increased acculturation leads to lower levels of psychopathology, less traditional more egalitarian sex roles, and that acculturation usually

accompanies more liberal attitudes as opposed to conservative attitudes.

Education

A study that examined the impact of education, grew out of the first author's clinical experience, where she encountered numerous examples of Puerto Rican women whose adoption of traditional sex roles presented conflicts that led to psychosomatic symptoms and depression (Soto & Shaver, 1982). The author took education and generation (either 1st or 2nd) to be a predictor of increased assertiveness and improved mental health. In comparing education with generation, education was more important and powerful than generation in affecting sex role traditionalism. Overall, 2nd generation and more educated women were less traditional than their counterparts.

Rosario (1982) also looked at the variable of education and generation to measure traditionalism among Puerto Rican women, and as in the Soto & Shaver (1982) study, the Attitude Towards Women Scale was used. However, in the former study generation spanned from 1st to 3rd and in addition, religious affiliation, religiosity and marital status and whether the respondent had children were also measured. Rosario found that women born in the US and 3rd generation women were more liberal than those of the 1st generation. The women of the middle aged group (26-45 years old) were more liberal than the younger women (18-25 years of age) and the older age women (46-76 years of age); whereas, the women of the younger age group had more liberal attitudes than the older age women. In addition, single women and women who were unmarried but living with a man had more liberal attitudes than women who were married. Women with children were more conservative than women with no children. Education was a key factor in liberality of attitudes. Women with at least some college education had the most liberal attitudes;

while those with a 6th grade education or less were the least liberal. Finally Catholic women were more liberal than non Catholic women (i.e. Protestant). The author speculates that since in a large majority of the women sampled, the husband was the main wage earner, the roles of mothering and of being a wife may have conflicted with obtaining employment. Consequently, she suggests that employment may affect family relationships and attitude towards sex roles.

Employment

Women's employment outside of the home coincides with more liberal attitudes. In Mexican American families where the wife worked outside the home, there was a more egalitarian style in the marriage (Baca-Zinn, 1980). Vazquez-Nuttal et al. (1987) reported on a study conducted by Pacheco (1981) who looked at women professors from Puerto Rico and that although they held contemporary attitudes towards vocational, intellectual and marital roles, they expressed less liberal attitude than their counterparts in the US. It remains unclear as to whether more liberal attitudes influenced employment or that employment influenced more liberal attitudes. A recent study conducted with professional Puerto Rican women living on the island found that sex role attitudes are in rapid transition, where most of the women described themselves as transitional or egalitarian in their sex role orientation (Cofresi, 1996). The author points out that women in the study "keep aspects of traditional roles such as the importance of motherhood and of keeping an orderly home; modify aspects of the traditional role ideal such as the importance of being flexible in a marriage; and reconstruct what they consider out-dated sex role practices such as sexual passivity and sexual submission." The extent to which these conflicts increase and give rise to depression will be explored in the next section.

Depression and Latina Women

Puerto Rican women are confronted by a multiplicity of stressful situations among them poverty, disintegration of family ties, change of values, discrimination and pressure of acculturation (Comas-Diaz, 1982). This truth can be said about all ethnic minority women, and certainly applies to women of other Hispanic groups. It is the interplay of these factors that can lead to lowered self esteem, loss of identity, feelings of powerlessness and depression. In fact, as Comas-Diaz emphasizes in discussing implication for mental health services, depression is an area that requires special attention since often it is not described by its sufferers as their primary problem. Instead women complain of insomnia, eating problems, headaches, fatigue, muscle weakness, pain, cramps, numbness and nervous attacks. They report feeling weak, exhausted and bored or having no energy, feelings, that take the form of vague suicidal ideation expressed by the phrase, "I wish I could just disappear".

Given the *marianista weltanschauung*, women experience what Espin (1982) describes as a unique combination of power and powerlessness where being a martyr is a characteristic of being a "good woman." Espin speculates that the high incidence of somatic complaints presented by low-income Hispanic women is directly related to their position of self-sacrifice. In effect, what the voice can not express the body expresses. Espin (1987) provides an explanation of why this occurs, "It is possible that traditional Latinas have few other ways to seek help, or that generally they are only aware of "feeling bad without being able to pinpoint the source of those feelings" (p. 491). Espin adds that women may lack familiarity about what to talk to a doctor about, and this lack of knowledge may also influence the tendency to somatize. Moreover, psychotherapy may

be seen as a betrayal of the privacy of family life.

Yet, despite the research focusing more on race and ethnicity, the empirical research on Latinas and Depression is still scant. Most studies drew populations from outpatient clinics or university settings and do not investigate the prevalence of depressive disorders in the general population (Arce & Torres-Matrullo, 1978; Torres-Matrullo, 1976; Soto & Shaver, 1982). To date, there is only one study that approaches an epidemiological study that examined the association of gender with the prevalence of both depressive disorders and symptomatology in a probability sample of adult Puerto Ricans (Canino, Rubio-Stipec, Shrout, Bravo, Stolberg, & Bird, 1987).

Canino et. al.(1987) take an *a priori* stand that the gender differences found in the prevalence of depression are due to social causation based on sex roles as opposed to biological susceptibility. Towards this end, demographic, social and health variables associated with gender difference and the prevalence of depressive conditions in Puerto Rico were examined. The demographic variable consisted of age, level of education and whether they lived in rural or urban areas. Employment and marital status were the social variables explored since they relate directly to social roles. In looking at the interaction between gender and social roles, it was hypothesized that employed married men and women would differ in symptomology since it is the interaction between the two variables, as opposed to either marriage or employment alone that would lead to depression. The researchers were led to this hypothesis on the basis that sex role differentiation is strongly supported in Puerto Rican society, where men are expected to work outside of the home, while women are expected to be homemakers. As a result, women who do work, do not get relief from their responsibilities at home. The Diagnostic Interview Schedule (DIS) was

used and it contained DSM-III, Diagnostic Statistical Manual of the American Psychiatric Association, diagnostic categories .

Lifetime diagnosis of DIS/DSM-III depressive disorders was found to be significantly more prevalent among women than men. However, there was no significant difference between men and women in the diagnosis of major depressive episodes. Dysthymia, 4.75 times more frequent in females, was found to be significantly more prevalent among women than men. In comparison to US urban areas, the rates ranged from 1.85 in Los Angeles to 2.57 in St. Louis. Canino et al. (1987) conclude, "the higher sex ratio in Puerto Rico is consistent with our theoretical model which postulates that Puerto Rican males and females have a different vulnerability to depressive disorder because of the more patriarchal social context in which they are socialized" (p. 454). Moreover, even after controlling for demographic, social role and health variables, Puerto Rican women report higher rates of depressive symptoms than men.

In another study that looked at gender differences, the relationship between gender and ethnicity with psychosocial and generalized distress was examined among Hispanics, Mexican Americans and Anglo-Americans (Salgado de Snyder, Cervantes, & Padilla, 1990). It was found that females reported more stress than males on the Hispanic Stress Inventory (HSI) and on the Center for Epidemiological Studies Depression Scale (CES-D). There are two versions of the HSI, one for immigrants and one for US born Hispanics. The HSI assesses the generalized construct of psychosocial stress across different life domains. This study is unique in comparing US born Hispanics with immigrants, and in comparing both of these groups with Anglo American. The findings suggest a strong correlation between both immigration stress and cultural/family conflict as measured by the

HSI, and generalized psychological distress as measured by the CES-D among immigrants of both sexes. However, immigrant females had higher levels of stress associated with cultural/family conflict as well as higher scores on the measure of Generalized Distress. These findings suggest that immigrant females may be more negatively affected by the immigration process than males. Also, immigrant females experience greater degrees of stress associated with family and personal issues during migration than males. The authors speculate that changing from a society that emphasizes definite roles for males and females (e.g. Latin America), to one in which there is greater freedom in sex role behaviors and otherwise unchosen behaviors that might be economic necessities, can affect one's sense of self identity and be a source of family conflict. This vulnerability to depression may be related to women's need for connection that will be discussed later.

A study that examined depression among 126 working Hispanic women ranging in age from 18 to 65, looked at the extent to which role conflict, life satisfaction, self esteem, instrumentality, expressiveness, age and education predicts dysphoria (Napholz, 1994). The instrument used was the Personal Attributes Questionnaire (PAQ) that contains separate masculinity and femininity scales each that measure instrumental and expressive trait dimensions. Other instruments included the Beck Depression Inventory, the Role Conflict Questionnaire for Women, the Rosenberg Self Esteem Scale and the Satisfaction With Life Scale. The study was based on the finding that psychological well being is linked to sex role orientation, specifically where *instrumentality* or the ability to act upon the world, also known as masculinity, is related to a sense of mastery. The study looked at working women, examining the conflict that can ensue when there are multiple role demands. Napholz (1994) hypothesized that there would be an inverse relationship

between instrumentality and depressive scores and a direct relationship between femininity and depressive scores. The results indicated that instrumentality and self esteem had an inverse relationship with dysphoria. In addition, life satisfaction and self esteem had a significant positive correlation with each other and significant negative correlation with role conflict. There was a significant positive correlation between role conflict and depression. She suggest that in counseling Hispanic women who present depressive symptomatology, “a focus on socially desirable attributes, traditionally thought of as masculine in our culture, may serve to enhance self esteem and life satisfaction and reduce depressive symptomatology and role conflict” (p. 506). But she cautions that merely encouraging American values such as assertiveness may not be useful since it has no direct cultural counterpart within the Hispanic culture. Normalizing traits of instrumentality, however, by reframing these traits needs to be provided.

Theoretical Frameworks of Depression

Before beginning to discuss the theoretical frameworks that provide an understanding of depression, it is useful to consider the behaviors that constitute depression and the different types of depression that exist. The Diagnostic and Statistical manual of the American Psychiatric Association, IV ed. (APA, 1994) lists several types of depressive disorder that are all classified as Mood disorders. They are: Major Depressive episode (single or recurrent), Dysthymic disorder; Bipolar Disorder I (single manic episode), Bipolar Disorder II Recurrent Major Depressive Episode with Hypomanic Episode. In addition, there are features that can accompany Mood Disorders such as catatonic, melancholic, psychotic and atypical features with postpartum onset, seasonal pattern rapid-cycling, and substance-induced mood disorder. The symptoms include: depressed mood (e.g. feels sad and empty,

appears tearful), poor appetite, weight loss, weight gain, insomnia or hypersomnia, markedly diminished interest or pleasure in all or almost all activities, psychomotor agitation, feelings of worthlessness excessive or inappropriate guilt, fatigue or loss of energy, diminished ability to think or concentrate. These diagnostic categories are based on behaviors observed from both a quantitative view (i.e. the array of symptoms) and a qualitative one (i.e. a difference in severity). While there is little disagreement about the symptoms there are a variety of theoretical formulations.

In his seminal work on elucidating the difference between mourning and melancholia, Freud (1917) regards both as sharing several mental features; both display, “a profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity” (p. 248). They differ in that mourning always has a clear precipitant, for instance the loss of someone, whereas, in the case of melancholia it can be precipitated by object loss, either real or idealized. More importantly, they differ because in the case of melancholia there is a lowering of self regard, or a “loss in regard to the ego.” As Freud succinctly stated, “In mourning it is the world which has become poor and empty; in melancholia it is the ego itself....In the clinical picture of melancholia, dissatisfaction with the ego on moral grounds is the most outstanding feature” (Freud, 1917, p. 249). Here Freud clearly implicates the agency of the superego in the development of this disorder. In other essays Freud asserts that female moral development never reaches the heights of male moral development because women lack the necessary castration anxiety for the demolition of the oedipal complex. This castration anxiety allows for the abandonment of incest and for the formation of the superego that agency of the mind that represents, conscience and morality. Freud then concludes, “...for women the

level of what is ethically normal is different from what it is in men. Their super-ego is never so inexorable, so impersonal, so independent of its emotional origins as we require it to be in men” (1925, p. 257-258).

Kohlberg’s work on moral development, while following a Piagetian developmental model, went onto to expand Freud’s conclusion of female moral inferiority. He derives six stages of moral development from a sample where no girls were included. His research involved asking subjects to make judgments upon moral dilemmas presented in a series of vignettes. Subsequent testing of his stage theory led him to conclude that women rarely attain levels beyond the third stage, where morality is conceived in interpersonal terms and where good behaviors mean having good motives and considerations. Stages 5 and 6 take on a idealized look at how people coordinate their interest. Kohlberg proposed that as a general rule the higher you progressed in the stages of moral development, the more predictable and responsible were your judgments since they were rule based and objective. His research was criticized as flawed in both its methodology and substance since he used only males in the original study, and his structuring of the stages of moral development reflected a male bias.

It was Carol Gilligan’s in her ground-breaking book, *In a Different Voice* (1982) who not only criticized Kohlberg’s methodology as being sex biased, but raised the theoretical suppositions that development proceeds along more than one line, including a line of development that is distinctive for each sex. For males, advanced moral development revolves around rules, principals and an ideal of formal justice; whereas, for females morality centers on caring and compassion. One is concerned with the ethic of care, the other with the ethic of justice. Gilligan asserted that these different orientations

grow out of different unfolding sequences of stage development. Whereas male development is characterized by successive stages of separation individuation, female development forms from differing types of connections within relationships. Women's identity is formed from the ability to remain connected while asserting and maintaining a distinct sense of self. Men's identity is formed by separating from attachments and focusing on aspects of self development such as autonomy and competence (Gilligan, 1982; 1990). The pitfall for women is to confuse connection with self-sacrifice. Gilligan (1982) quotes Elizabeth Cady Stanton as saying, "the thing which most retards and militates against women's self-development is self-sacrifice" (p. 129).

Paralleling Gilligan's work, clinicians at the Stone Center are developing a picture of women's psychological development based on the importance of responsiveness in relationships and empathy in women's lives. Initially called "self-in-relation" theory, it is also referred to as the "relational self". It differs from the interpersonal or object relations theory because of the emphasis on mutuality in the relationship. Mutuality refers to the bi-directional movement of thoughts, feelings and activity between people in a relationship (Genero, Miller, Surrey & Baldwin, 1992). The primary organizing experience for women is to remain connected and attain the capacity to be attuned to the affect of others, thus, participating in the development of others (Kaplan, 1986). Empathy is a precursor to the development of the relational self, and as Jordan (1986; 1991) indicates, a complex psychological process that allows one to experience the psychological state of another person involving an affective surrender and a cognitive restructuring. Jordan (1986) reports that research indicates that women are more empathic than men except when it comes to being empathic to the self or self-empathy. She attributes this to women being

conditioned to attend first to the needs of others, accompanied by guilt stemming from claiming attention to the self. Stiver (1991) traces women's empathic capacity to the mutual identification of the early mother-daughter relationship.

Kaplan (1991) presents a cogent analysis for women's vulnerability for depression from a relational perspective. She proposes that key elements of depression are distorted aspects of women's normative development. First, she examines the central key elements found in depression and the relevant theories associated with each element, and then she critiques and expands these theories in light of what is known about women's development. The key elements of depression according to Kaplan are the experience of loss, the inhibition of action or assertiveness, the inhibition of anger and aggression, and lastly low self esteem. The experience of loss, whether it be real or imagined was described by Freud, but it has also figured prominently in Beck's (1972) cognitive behavioral theory that sees depression as composed of a cognitive triad. This triad includes a negative view of the self, negative view of the world, and a negative view of the future.

Inhibition of action and/or assertiveness has been associated with depression and it is typified by Beck's cognitive triad but also by Seligman's learned helplessness, where the consequence of not having control is linked to the failure to act. Inhibition of anger was seen by Freud as an underlying dynamic of depression and it is described as occurring from an emotional loss that leads to the loss object being internalized, resulting in what Freud elegantly termed as anger being turned against the self. Finally, low self esteem has long been associated with women psychological make-up dating back to Freud's concept of penis envy and the lack of castration fear in women. It is central in any understanding of depression. Kaplan conceives of low self esteem as the end process of all the other

elements and it is associated with deep feelings of worthlessness and inadequacy.

In critiquing these theories of depression, Kaplan points out that both the relational model and the analytic theory link loss as a precursor to depression. However, the similarities end there because in the analytic model the loss is one interpersonal direction, where a person is not getting their narcissistic needs met. Kaplan highlights that Kohut continues in this same vein when he emphasizes that low self esteem develops from feelings of being wounded or neglected in relationship to others. Relational theory, on the other hand, posits that what is lost in loss is not just narcissistic supplies, but what one can contribute to another person's growth and development. One misses receiving from another but also giving or participating in another person's life. The essence of the loss is not being in a mutually affirming relationship where one's validity is affirmed as a person-in-relation.

Kaplan's exposition removes concepts of loss from reified airless vacuum where the self is conceived as a discrete unitary entity to one that appears more real, more tied to a reality where the self grows in relationship. While our minds may represent the loss of a person as acting directly upon us, given the idealization that the person comes under, it is clear the essence of the loss lies in the interaction with the person, whether the quality of the interaction is real or imagined; in effect it is the loss of the relational self that is the characteristic of this loss. In providing further clues for the importance of relational factors in depressed women, Kaplan reexamines the findings of the research of Brown & Harris (1978). This study found that low self esteem establishes a propensity for depression with social variables, e.g. loss of mother before the age of 11, the presence of three or more children under the age of 14, lack of paid employment and a lack of an intimate confiding

partner, all increase the risk for depression. Interestingly, Brown and Harris (1978) found that at a time of crisis, lack of support from a core relationship, i.e. an intimate partner is strongly associated with increased risk of depression. Conversely, Brown, Harris Adler & Bridge (1986) found that the presence of an intimate confiding partner provides protection from depression. Clearly these empirical results add validity to Kaplan's elucidation of the importance of relationships in women's lives. Finally, Kaplan cites various studies that indicate that the majority of women who seek help for depression were more likely to have suffered a relational loss within six months preceding onset of depression. Kaplan concludes, "that the absence of intimacy is experienced more centrally as a failure of the self even if accompanied by the failure of support or love from another".

In terms of inhibition of action and assertion, Kaplan agrees with Seligman that depression occurs if one is unable to predict or anticipate the consequences of one's own behavior, and such a lack of control leads one to give up with feelings of helplessness. However, Kaplan goes further than Seligman, indicating that the impact of learned helplessness upon the self engender feelings of self-blame. The only element missing from Kaplan's re-shifting of key elements to accommodate women's experience is the role of shame and as such there is no connection made between lack of control to feelings of shame.

Traditional dynamic theories emphasize that shame results from feelings that one does not measure up in another person's eyes. Helen Block Lewis (1987) notes that given women's increased sociability, decreased aggression, coupled with second class status, shame is more common to women than men. Lewis states, "shame is one of our species' inevitable responses to loss of love, whether in early childhood or in old age" (p. 183).

She goes on to describe the dynamic of shame as being “the empathic experience of the other’s rejection of the self” (p.185). Here the vital link between shame and empathy is evident where shame is a type of empathic experience. However, Lewis is concerned with the vinculum of shame to depression and draws upon several empirical studies that explore the affective phenomenology of depression where it was found that shame-prone people were more likely to be suffering from depression, than guilt-prone people. Lewis sees shame as also being able to counter a criticism of Seligman’s theory. The criticism goes as follows : based on Seligman’s theory that depressed people attribute negative events to their own failings, and that this tendency is characterized by *internal, stable* and *global* attribution, then depressed people are so helpless they should not feel self reproaches for what they are unable to control. Lewis illuminates the connection by saying that what depressed people are helpless about is to change the vicarious experience of the other’s negative evaluation, or to get out of the state of shame. Finally, Lewis presents evidence indicating that low self esteem, rather than feelings of guilt is linked to all types of depression and shame is the affective-cognitive state of low self esteem.

In relational terms shame is seen as a sense of unworthiness to be in connection with others, a deep sense of unlovability with awareness of how much one wants to connect with others (Jordan, 1989). Shame is a feeling state that involves extreme self consciousness but also signals one’s capacity for empathy. Jordan writes that shame is a silencing mechanism, a means of making women sublimate their anger. The paradox is that Jordan considers women to be vulnerable to shame because they long for connection and fear loss.

If in shame one experiences both affectively and cognitively other people's negative evaluation of the self, then it is not a leap to presume that one's own self evaluation is negative. Moreover, if one can imagine a multitude of other people's negative evaluation becoming a cultural imperative, then it is not difficult to understand the propensity for depression in women. As mentioned earlier, it is precisely these contentions that Dana Crowley Jack submits as the key to understanding gender differences in depression (1987, 1991); for Jack both the internal and external causes of depression need to be understood. Self reproach, self blame, feelings of worthlessness are all characteristics of depression as indicated by DSM IV (1992). Jack implies that critical in understanding female depression is understanding how women judge themselves. The author states, "self evaluation holds the key to understanding gender differences in the prevalence and dynamic of depression" (Jack, 1991, p. 92). This echoes back to Freud's statement on melancholia where there was "dissatisfaction with the ego on moral grounds" (1917, p. 249). She points out that regardless of the theoretical perspective from Freud to Gilligan, male and female morality differs where female morality is attuned to relationships and male morality is based on abstract principle. Jack (1987) sees unifying themes among the ego psychologist that attribute depression to the gap between the self one would like to be and the self one perceives one to be, and the different theories of Kohut and Winnicott where both agree that depression stems from children learning that their true self is not acceptable. In these various theories, Jack sees that the conflict between the actual and ideal state emerges from a conflict between the social context and the developing personality; "thus, self-evaluation provides a two-way mirror reflecting, on the one hand, outer social norms and cultural tradition regarding feminine goodness and correct behavior; and, on the other, the

woman's inner imperatives that direct her understanding of how she 'should' be in the relation to others" (Jack, 1987, p. 163-164). She refers to the standard that women judge themselves against as "model of goodness" (1987, p. 165). The problem for women, as Jack (1987) sees it, is when women try to fit their relational capacity to match societal expectations of what makes a "good woman" and that could lead to self-alienation and inauthenticity. In effect, women may be more vulnerable to depression because of the combined effects of gender norms and women's relational orientation.

In Jack's (1987, 1991) view, it is no wonder that depression is overdetermined in women given the cultural imperative that requires women to be selfless in order to maintain intimacy. Again the Brown & Harris (1978) study is reexamined. Jack (1987,1991) emphasizes that the critical variable that either provokes women to, or protects them against depression is *the quality of the relationship with her partner*. It is evident then, that a key factor of depression for women is when intimacy and mutuality remain elusive in a close relationship then despair and depression set in.

Drawing from attachment theory, where security in relationship fosters confidence and self reliance while insecurity elicits anxious attachment behavior, Jack posits that depressed women present a collection of attachment behaviors within a context of a relationship that resembles an anxious attachment. She refers to this phenomena as compliant relatedness and it is characterized by restriction of initiative, lack of freedom of expression, and suppression of anger. Women adopt this pattern, a pattern that is socially sanctioned and culturally prescribed particularly within the institution of marriage, in order to overcome distance and to connect intimately with their partner. Paradoxically women silence themselves in order to maintain intimacy but tremendous psychic energy is

expended in silencing the self, depression ensues as creativity is cut-off, and anger and conflicts are internalized (Jack, 1991). In essence, women silence themselves in order to maintain intimacy, and in the process experience a loss of an authentic connection to the self. This loss of self is what makes women vulnerable to depression.

In a longitudinal study that involved interviewing 12 depressed women, Jack (1991) reports that 11 women understood that care means being “unselfish” “giving” and “self-sacrificing.” Jack posits that women who seek attachment in self-sacrificing ways are likely to develop gender-specific schemas about intimate relationship. These schemas are collectively referred to as silencing the self, and involve the devaluation of personal experience, censorship of experience, repression of anger, and emotional deprivation. It is these silencing schemas that Jack believes contributes to loss of self-esteem and heightened vulnerability to depression. From the semi-structured interviews, Jack (1991) developed a scale that measures women’s beliefs and images of the self in intimate relationships; It is called the *Silencing the Self Scale*.

Application of Theoretical Frameworks of Depression to Latinas

In overlaying these theoretical formulations, exactly what picture emerges of depression among Latinas? How do we focus our lens so that they accurately reflect the details of lives of depressed Latinas? Jack’s theory provides an important perspective about the metaphor of silencing and its implication for depression, but what of the silencing of Latinas. It is important to note that an accompanying salient feature of silencing involves the suppression of anger, and feminist theorists have noted that the unexpressed anger can lead to a cycle of self-defeating behaviors that produce feelings of powerlessness (Lerner, 1985). Bernandez (1988) states that women do not express anger directly

because they fear a relational tie will be severed or more specifically fear of abandonment. However, when one looks at the context of the lives of Latinas it is apparent that the repression of anger is over determined.

The literature on Puerto Rican culture make it clear that there are proscriptions against the direct expression of anger (Comas-Diaz & Duncan, 1985). First, on a sociopolitical level the forces that shape Puerto Rican culture, colonialism and Catholicism can not be sufficiently emphasized. Relying on the formulation of Piers and Piers of the psychological mechanisms involved in migration, Comas-Diaz (1989) provides an insightful analysis of the emotional problems Puerto Rican women face in making a cultural transition. Under stress immigrants tend to spilt, and for Puerto Ricans this can have a political dimension regarding independence or statehood. Because migration leads to a regressive state, where separation from the host country is experienced as a well deserved rejection, migrants are unable to see themselves accurately. They reject themselves and identify with the aggressors in that they see themselves as the majority culture sees them. Although Comas-Diaz (1989) does not point this out, enabling this dynamic is the emotion of shame. Another dynamic that occurs is that of passing or pseudoassimilation, where migrants tend to fluctuate between wanting to belong and revulsion over this desire. This is further complicated among Puerto Ricans because as US citizens they do belong but they lack political power and have different language and customs. Comas-Dias (1989) states that “the Puerto Rican feels doubly rejected by the colonial power (a parental figure) and internalizes this rejection” (p.173). She concludes that this dynamic leads to the psychopathology of the colonized.

Second, on a more personal level the proscriptions against the direct expression of anger are numerous. Traditional Puerto Rican society tends to reinforce placing priority on the collective, nonassertive behavior, indirect communication of feelings and interdependence among females (Comas-Diaz, 1989). The direct expression of anger and even assertiveness are kept in check by: the extended family system, or familism, respeto (respect), verguenza (shame), traditional sex roles (Comas-Diaz & Duncan, 1985; Rivera-Arzola & Ramos-Grenier, 1997) as well as other cultural values. Respect is the lubricant of all hierarchical interactions and it is especially required with elders or males. According to Rivera-Arzola & Ramos-Grenier (1997), shame, viewed from a feminist perspective, promotes the repression of anger and women's submission to male control, with rejection as the penalty for insubordination. Within the language, there are plenty of terms and adages that support importance of shame (Rivera-Arzola & Ramos-Grenier, 1997). In fact, one insult is to refer to someone as having no shame; this insult becomes more potent even when applied to a woman, for a shameless woman ignores traditional sex roles. As such, it appears that shame is a quality that is prized, and the explanation for this may lie with Jordan's (1986) observation that shame signals the capacity for empathy. Furthermore Jordan (1986) states that motherhood requires, "a careful tuning to the other, a sensitive empathy to the subtle or unarticulated internal states of the infant." Given that motherhood is revered within the Puerto Rican culture, then there is ample opportunity for empathy to be transmuted into shame in preparing young girls and women to be mothers. Also, given Puerto Ricans' emphasis on the collective vis a vis familism, it is clear that Puerto Rican culture, and in fact other Latino cultures are more shame-based than guilt-based. However, Jordan also states that shame is a silencing mechanism against the direct

expression of anger; and this, as indicated above is implicated in female depression. Jack (1987) after discussing the power of social imperative in female depression, stated that it is no wonder depression is overdetermined in women. Similarly, in Puerto Rican women, and in other Latina groups, shame appears to be a overdetermined psychological factor. Just as in Block-Lewis analysis of studies where shame-prone people were prone to depression, Puerto Rican culture, which is shame-based, may render women more vulnerable to depression. Perhaps, it is when the psychological dimensions of the suppression of anger, the silencing of the self, the adherence to traditional sex roles, the experience of shame both personally and politically, intersect with the risk factors of poverty and discrimination, can we fully understand the reality of the lives of depressed Hispanic women.

Based on the foregoing, this study proposes to test the concept of silencing among Hispanic women. The sample will consist of two groups, one derived from a mental health clinic, another group derived from the same community but not attending the clinic. In testing the hypothesis it will treat the sample as a whole. It proposes to test the hypothesis that there is a significant positive relationship between traditional sex roles and depression. There is no scale that has been designed to measure *marianismo*. However, the *Inventory of Attitude Towards Men and Women* measures sex role stereotype and was developed using a multiethnic population (Coles, 1974). The second hypothesis is that the quality of the intimate relationship of Latina women will be correlated with depression regardless of their belief in traditional sex roles. Depression will be alternately measured by *The Beck Depression Inventory* and *The Silencing the Self Scale*. The *Relationship Assessment Scale* will measure the quality of intimate relationship. Finally level of education, obtained

from a social demographic questionnaire, will be negatively correlated with their beliefs in traditional sex roles irrespective of levels of depression.

Summary

Epidemiological studies have documented that depression is the leading mental health problem for women with rates reported to be twice that of men and some studies indicating a ratio of 3 to 1. Hispanic women are no exception to the rule, and in fact may be a higher risk because as a group they are more likely to have a preponderance of risk factors.

More is known about the diagnosis, treatment and recovery from depression than the etiology of this illness. However, contemporary advances in the psychology of women have gone far in explaining how cultural forces interact with adult women's development to create a vulnerability to depression. There is sufficient empirical evidence to suggest that the quality of women's intimate relationship can either protect or provoke depression. Dana Crowley Jack recently developed a theory to explain women's vulnerability to depression that incorporates ideas from women's moral development, attachment and self-in-relation theories. Jack proposes that women tend to silence themselves in order to maintain intimacy, and in the process experience a loss of an authentic connection to the self. This loss of self is what makes women vulnerable to depression. She developed the *Silencing the Self Scale (STSS)* which measures gender-specific beliefs and behaviors about intimacy. Preliminary reports indicate that this scale is moderately correlated with the *Beck Depression Inventory*.

Feminist scholars have linked the repression of anger to low self esteem, feelings of helplessness and depression. In addition, traditional sex roles have been linked to

depression. Puerto Rican cultural values discourages the expression of anger or assertiveness especially among women. Marianismo, a cultural concept that informs behaviors of Latinas encourages passivity, self- sacrifice and the repression of anger.

This research will explore how self- silencing and self-sacrificing behaviors contribute to depression in Latinas. This study will examine the construct of self- silencing within intimate relationships among Latina women drawn from a group attending a mental health clinic diagnosed as depressed, and a group obtained from the community, who are not depressed. It will investigate the relationship between adherence to traditional marianismo sex roles, and depression, where traditional sex roles will be measured by the *Inventory of Attitude Towards Men and Women Scale*. It will also look at the degree to which there is satisfaction in an intimate relation as measured by the *Relationship Assessment Scale* and compare it to levels of depression. It will examine the relationship between education and belief in traditional marianismo sex roles.

Chapter 3

Methodology

This study will explore the construct of self-silencing within intimate relationships and relationship satisfaction among Latina women drawn from a group attending a mental health clinic diagnosed as depressed, and a group obtained from the community, who are considered normal. It will examine the relationship between traditional sex roles and depression, and it hypothesizes that there will be a significant positive relationship between belief in traditional sex roles and depression among Latina women. Second, it hypothesizes that the lower the level of relationship satisfaction the higher the level of depression regardless of these women's belief in traditional sex roles. Lastly, it hypothesizes that the level of education will be negatively correlated with their beliefs in traditional sex roles, regardless of their level of depression.

Subjects

The Clinic group. Forty-five Latina women were recruited from a mental health clinic affiliated with an inner city medical center. They were diagnosed as depressed. As part of their treatment they were receiving group therapy. Recruitment of participant was conducted prior to the beginning of a group therapy session. Volunteers were administered protocol questionnaires during scheduled hospital visits in a small group setting. The mental health clinic serves a predominantly immigrant Latino population. All subjects indicated Spanish as their first language. For a description of the demographic variables depicting the demographic variables refer to Table 1-2.

The Community group. Forty-one Latina women were recruited from a community center that sponsors an adult education program, that includes classes in

English as a Second Language. All subjects reported Spanish as their first language. Recruitment was conducted at the beginning of their class. Questionnaires were administered to volunteers during scheduled clinic visits in a small group setting. For a description of the sample depicting the demographic variables refer to Tables 1-2.

TABLE 1.

DESCRIPTION OF SAMPLE DISTRIBUTION BY PERCENTAGE¹

		BOTH GROUPS	COMMUNITY GROUP	CLINIC GROUP
A. MARITAL STATUS	SINGLE	15.1	17.1	13.3
	MARRIED/ PARTNER SEPARATED	38.4	65.9	13.3
	DIVORCED	27.9	9.8	44.4
	WIDOWED	12.8	7.3	17.8
	WIDOWED	5.8	0	11.1
B. COUNTRY OF ORIGEN	Puerto Rico	39.5	7.3	68.9
	Dominican Rep.	18.6	14.6	22.2
	Mexico	16.3	34.1	0
	Columbia	4.7	7.3	2.2
	El Salvador	1.2	2.4	0
	Honduras	2.3	4.9	0
	Other*	17.4	29.3	6.7
C. EMPLOYMENT STATUS	Working	14.0	24.4	4.4
	Not Working	86.0	75.6	95.6
D. HISTORY OF PSYCHOTHERAPY	YES	55.8	7.3	100
	NO	44.2	92.7	0

¹ In the demographic questionnaire subjects were asked to differentiate between country of birth and country where they were raised. In 100% of the sample the country of birth and the country where they were raised were identical. In another question, the subjects were asked to indicate their partner's gender. The response indicate that 100% of the sample is heterosexual. Neither of these variables are represented in the table.

Table 2.

CONTINUOUS MEASURES AND THEIR DISTRIBUTION

<i>VARIABLE</i>	<i>MEAN</i>	<i>STANDARD DEVIATION</i>
NO. OF YEARS LIVING WITH PARTNER	2.09	1.32
EDUCATION	10.05	1.55
AGE	42.44	11.57
NO. OF YEARS IN THE US	15.31	12.68
NO. OF CHILDREN	2.53	1.61

Instruments

Four standard instruments and a short demographic questionnaire were administered in this study: *The Silencing the Self Scale* (Jack & Dill, 1992); *The Beck Depression Inventory* (Beck, Ward, Mendelson, Mock & Erbaugh, 1961); *The Inventory of Attitudes towards Men and Women* (Coles, 1974); *The Relationship Assessment Scale* (Hendricks, 1988).

The Silencing the Self Scale (STSS) is a 31 item self report questionnaire designed to measure key dimensions that are thought to reflect the dynamic of depression. It has four subscales that have been rationally derived; they are: (a) **externalized self-perception** which refers to judging the self by external standards; (b) **care as self-sacrifice** refers to securing attachments by putting the needs of others before the self; (c) **silencing the self** refers to inhibiting one's self-expression and action to avoid conflict, and the possible loss of a relationship, and (d) the **divided self** refers to presenting an outer compliant self to live up to feminine role while the inner self grows angry and hostile (Jack & Dill, 1992). Jack

and Dill (1992) reported internal reliability coefficient ranging from .86 to .94 that were derived from three samples (N=63, N=270, N=140). The STSS correlated significantly with the Beck Depression Inventory (.50), which provided for its construct validity. The scale is based on a model of female depression and in the standardization, a case is made for the using the scale as a measure of depression. Please refer to Appendix C.

The Beck Depression Inventory (BDI) is a 21 item self-report measure of the presence and degree of depression. It measures the severity of depression along a continuum from health to illness. Each item assesses an attitude or symptom of depression. The symptoms or attitudes are: sadness, pessimism, sense of failure, lack of satisfaction, guilty feelings, sense of punishment, self-hatred, self-accusations, self-punitive wishes, body image, work inhibition, sleep disturbance, fatigue, loss of appetite, weight loss, somatic preoccupation, and loss of libido. Beck et. al (1961) reported an internal consistency reliability for the BDI of .86 on the basis 38 psychiatric patients. The inventory correlates with the Depression Adjective checklist (.66) and the Minnesota Multiphasic Personality Inventory Depression (.75). Please refer to Appendix D.

The Inventory of Attitudes Towards Men and Women (IAMW) is a 34 item Likert-type questionnaire with six responses ranging from strongly agree to strongly disagree (Cole, 1979). The items tap into different sex role expectations for males and females (e.g. virginity, household responsibility) and differentiate degrees of traditionalism among subjects. Internal reliability coefficients was reported to be greater than .90 for the complete sample and for six subsamples. In all instances alpha coefficients exceeded .90. The ethnic composition of the sample included Caucasians, African Americans and of Puerto Ricans (Cole, 1979). Please refer to Appendix E.

The *Relationship Assessment Scale* (RAS) is an 8 item Likert-type questionnaire with five responses. The scale is a generic measure of relationship satisfaction. According to Hendricks (1988) the measures tap several relationship dimensions (e.g., love, expectation of problems) yet general enough to apply to married and non-married couples. It is reported that the RAS has a alpha reliability of .86. The RAS has a .80 correlation with the Dyadic Adjustment Scale, (Hendricks, 1988), a standard measure of marital relationship. The RAS is easy to administer and this is of special consideration since the participants had to respond to a long battery of questionnaires. Please refer to Appendix F.

The Spanish version for each of the four scales are available. The Beck Depression Inventory is available in Spanish. The Silencing the Self Scale was translated into Spanish as part of an earlier study (Rivas-Olmeda, 1992). Hendricks made available a Spanish version of the Relationship Assessment Scale. All subjects indicated that their preferred language was Spanish.

Also included was a demographic questionnaire prepared by this investigator (Appendix B) that elicited the information represented in Table 1.

Procedures

The subjects from the Clinic group were recruited with the help of informative flyers that were distributed by therapists, who provided a verbal explanation of the study as, "a chance to participate in a study that explores the thoughts and feelings of Latinas." A consent letter was distributed to those who expressed interest in participating. The contact was for a two week period. The first week, subjects were given both a recruitment and consent letter (Please see Appendix A). The second week subjects were given the three questionnaires and the demographic survey for a period of 1 hour.

Participants from the Community group were recruited from a community center with two different satellite locations. Informational flyers were distributed and the teachers provided a verbal explanation indicated above. The first week involved recruitment of subjects and obtaining consent. The second week involved responding to the questionnaires.

Participants from both samples that were interested in obtaining a summary of the research signed a separate sheet indicating their names and mailing addresses. They were informed that at the conclusion of the study, they would be provided with such a summary of the results. This was done.

Chapter 4

Results

The hypotheses from the measures were calculated for the study participants as a whole. Further statistical analysis involved comparing the two groups, the depressed Clinic group and the Community group. All of the women were of Latina background.

To test these hypotheses, correlation coefficients, stepwise multiple regression, analysis of variance and Chi Square tests were the procedures employed.

TESTING OF HYPOTHESES

HYPOTHESIS 1. There will be a significant positive correlation between the occurrence of belief in the traditional marianismo sex roles for women and depression among Latina women.

To test this hypothesis a correlation coefficient was computed where the Beck Depression Inventory (BDI) was utilized as the depression measure and the Cole's Inventory of Attitude Towards Men and Women (IAMW) as the measure of marianismo. A correlation coefficient $r = .19$ at a $p = .05$ was obtained, indicating a weak, statistically significant relationship. Using the BDI as a measure of depression, hypothesis #1 is sustained.

However, using the Silencing the Self Scale (STSS) as a measure of depression yielded similar results. A correlation between the STSS and IAMW yielded an $r = .40$, at a $p = .05$, indicating a positive statistically significant relationship of moderate strength.

Thus, when STSS is the measure of depression, the relationship between depression and sex roles is significant and of moderate strength. Therefore, there is a significant moderate correlation between beliefs in traditional, marianismo, sex role and silencing of the self in Latina women.

HYPOTHESIS 2. Women who report lower level of relationship satisfaction will have higher levels of depression, regardless of their belief in traditional sex roles.

To test this hypothesis the Relationship Satisfaction Scale (RAS) and the BDI were utilized while controlling for the IAMW and a partial correlation coefficient was computed. An r of $-.47$ with a $p \leq .05$ was obtained indicating a statistically significant negative relationship of moderate strength between women's satisfaction with their relationships to their mate and their general level of depression. To put it another way, the happier women are in their relationship, the less depressed they are.

In the case where the STSS was used as the measure of depression, the partial correlation coefficient between STSS and relationship satisfaction, while controlling for traditional sex roles is $r = -.29$, with $p \leq .05$. This indicates a negative statistically significant relationship of weak strength. The more the women silenced themselves, the less satisfied they were with their intimate relationships. Hypothesis 2, therefore, was sustained.

HYPOTHESIS 3. The amount of education of Latina women will be negatively correlated with their beliefs in traditional marianismo sex roles for women regardless of their level of depression.

To test this hypothesis, a partial correlation coefficient was computed using the IAMW and the reported level of education, while controlling for their scores on the Beck Depression Inventory. An r of $-.30$ at a significance level of $p=.05$, indicates that there is a statistically significant negative relationship between subjects' level of education and their belief in traditional marianismo sex roles. Hypothesis 3, therefore, was sustained.

Table 3.

Intercorrelations of the BDI, STSS, IAMW and RAS*

	BDI	STSS	IAMW	RAS
BDI	1.000	.492	.193	-.468
STSS	.492	1.000	.400	-.286
IAMW	.193	.400	1.000	-.019
RAS	-.468	-.286	-.019	1.000

* $p=.05$ Key: BDI= Beck Depression Inventory; STSS= Silencing the Self Scale; RAS= Relationship Assessment Scale; IAMW= Inventory of Attitude Toward Men and Women

The second way, and more powerful method of analyzing the data, is to compare the groups and determine the degree to which the STSS, RAS and the IAMW is implicated in the women's scores on the BDI. The Clinic group consisted of self-identified depressed women who were not only clinically identified as such, but were also being treated for their depression. The Community group consisted of women who

were not selected according to any particular criterion. The groups' status on depression was confirmed by their standing on the BDI, and therefore, group membership is a variable. A one-tailed t- test for the difference in means on the BDI was computed. Please refer to Table 4 for the differences of means between the groups.

Table 4.

Differences of Depression Scores on the BDI by Group*

VARIABLE	MEAN on BDI	STANDARD DEVIATION
Community	12.37	9.5
Clinic	25.78	9.6

*significant at p=.000, 1 tail

The mean difference on the BDI between the Community and the Clinic samples is 13.41. This is significant at a p level of .000. Another way of establishing the relationship between group membership and depression is to compute the correlation coefficient between group membership and the BDI. In this case, $r = .58$ at $p < .00$ indicates that it is a statistically significant positive correlation between the BDI and membership in a particular group. Both the t-test and the correlation coefficient establishes that the members of the Clinic group score at an appreciably greater level of depression (greater than 100%) than do members of the Community group. Group membership, therefore, is a valid way of distinguishing between depressed and non-depressed women.

Thus, there is clearly a definite difference between the Clinic and Community groups, where the Clinic group is depressed and the Community is not. However, in order to determine whether the difference between the groups in depression is not due to uncontrolled differences, the groups were compared on demographic variables. Responses

to variables that fall into discreet categories, such as marital status, country of origin and employment history will be analyzed below.

A Chi-Square test was done for the variable of marital status. The findings indicate that a majority of the Community group was married or living with a partner, while the majority of the Clinic group was not married or living with a partner and was either single, separated, divorced, or widowed. Table 7 summarizes these results where the categories of single, separated, divorced and widowed are collapsed into one variable known as “single”, while married or living with a partner were collapsed into another variable known as “married”. Table 5 summarizes these results.

Table 5.

Variable	Comparison of Marital Status by Group		χ^2	df	p=
	Community	Clinic			
single	34.1	86.7	25.02	1	.00**
married	65.9	13.3			

** p significant at the .001 level

Clearly, the Community and the Clinic are significantly different on marital status. The Clinic sample is much less likely to be married or living with a partner.

In looking at differences between the groups with respect to country of origin, a preliminary Chi square test revealed that a majority of the Clinic group, 68.9%, was from Puerto Rico. The second most predominant place of birth for members of the Clinic group was the Dominican Republic, with 22.2% of these women from there. The third ranking place of origin at 2.2% was Columbia. By contrast, the majority of members of the Community group was from Mexico, 34.1%. The second most numerous were from the Dominican Republic, 14.6%, while members from Puerto Rico accounted for 7.3%. Less

than 5% of the Community group members identified themselves as migrating from El Salvador and Honduras, whereas 29.3 % designated themselves as “other”. Those countries were Guatemala and Peru. A further analysis between the groups was conducted where all the countries of origin were collapsed into the category “other” and it was compared with Puerto Rico, the largest group. Table 6 summarizes these results.

Table 6.
Place of Birth of the Subjects

GROUP	Community	Clinic	χ^2	df	p=
Puerto Rico	7.3	68.9	34.02	1	.00
Other	92.7	31.1			

Clearly, the Community and the Clinic samples differ in their countries of origin. The Clinic sample is much more likely to be from Puerto Rico, whereas the Community group members are more likely to come from a Latin American country.

The same analysis was brought to bear on whether there were significant differences between the groups in terms of employment and involvement in psychotherapy. Table 7 summarizes these results

Table 7.
Employment and History of Psychotherapy by Group

Variable	Community	Clinic	χ^2	df	p=
employed	24.4	4.4	7.11	1	.00**
not employed	75.6	95.6			
history of therapy	7.3	100	74.73	1	.00**
no history of therapy	92.7	none			

** p significant at the .001 level

The Clinic sample is less likely to be working than the Community sample; however, both groups of women are not likely to be working. In other words, only 14% of the combined sample have a job. One hundred percent of the women in the Clinic sample, as a requirement of selection, have had psychotherapy. Only 7% of the women Community sample acknowledge having had psychotherapy.

The following analysis will look at the demographic variables that lie on continuums, which are age, years living in the US, years living with a partner, highest educational level attained, and number of children. For each of these variables a one-tailed t-test for independent sample was computed for determining the similarities or differences between the groups. Table 8 summarizes these findings.

Table 8.**Characteristics of Continuous Variables by Group**

Variable	Community		Clinic		t	df	p=
	Mean	SD	Mean	SD			
Age	33.12	7.8	50.9	7.0	11.17	84	.00**
Years in the US	7.68	6.2	22.27	13.11	-6.68	64.08	.00**
Years living with partner	2.37	1.32	1.84	1.28	1.86	84	.07
Grade	10.63	1.69	9.51	1.18	3.53	70.49	.00**
No. of children	1.90	1.26	3.11	1.69	-3.72	84	.00**

**p significant at the .001 level

The significant results indicate that the Clinic sample is nearly 18 years older, on average, than the Community sample. The Clinic sample has been in the US nearly 3 times as many years as the Community sample. The Clinic group is less educated, on average, by approximately 1 year than the Community sample. Finally, the Clinic sample has significantly more children (3 vs. 2) than the Community sample. There were no significant differences between the groups in the number of years they had been living with their partner.

However, identifying the demographic variables that differentiate between the groups does not mean that they are consequential in the analysis. Therefore, a stepwise regression analysis was conducted to identify potential predictors or those variables, which not only differentiated between the Community and the Clinic samples, but also demonstrated statistically significant relationships to the Beck Depression Inventory (BDI).

Two variables-- marital status and age-- were identified as being associated with

depression. Substantively, these findings indicated that older women (Beta =.29, p=.01) and women who were not “attached”, i.e., not married or living with someone (Beta = -.29, p=.01) were significantly more likely to be depressed. Therefore, age and marital status are predictors for depression. All the other demographic variables that differ between the groups are either explained by age and marital status, or they are irrelevant to the level of depression.

Once it has been established that the Clinic group and the Community group differ on age and marital status, it is important to control for these differences. This is accomplished by eliminating these effects, and then the difference between the groups on depression should become smaller. These two variables, age and marital status, were used as covariates in an analysis of covariance, where the two groups were compared on the BDI, after adjusting for age and marital status differences. Table 9.

summarizes these results.

Table 9.

Adjusted and Estimated Means Between the Groups on the BDI*

Group	Observed Means	Adjusted Means
Community	12.36	12.68
Clinic	25.78	25.46

*significant at p=.000, 1 tail

The difference in depression, as rated by the Beck Depression Inventory between the Community and the Clinic samples, is statistically significant even after removing the differences between these two groups on age and marital status. Prior to removing the effect of age and marital status, the difference in mean on the BDI is

13.42, whereas after the difference decreases to 12.78, or only by .64. From this, it is concluded that pre-existing differences between the two groups, which are related to depression, do not explain the difference in depression. To restate another way, age and marital status are not significantly related to the outcome and by that fact, they are not able to account for differences between the groups. Moreover, a look at the adjusted means indicates that there is virtually no adjustment signifying that age and marital status do not explain the difference between the Clinic and the Community samples on the BDI.

An alternative explanation as to why the groups differ on the BDI brings us to account for the STSS, the RAS and the IAMW. The differences are due to the fact that depressed women have a greater tendency to silence themselves, as measured by the STSS, have stronger adherence to belief in traditional, marianismo, sex roles, as measured by the IAMW, and to their experiencing less satisfaction in their intimate relationships, as measured by the RAS. Therefore, the groups differ on depression because they differ significantly on the STSS, IAMW and the RAS. Table 10 summarizes these results.

Table 10.

Comparisons of the Community and Clinic Group: STSS, IAMW and the RAS

Variables	Community		Clinic		t	df	p
	Mean	SD	Mean	SD			
STSS	83.37	15.47	99.76	11.91	-5.53	84	.00**
IAMW	104.02	17.37	116.88	16.40	-3.53	84	.00**
RAS	25.85	8.0	18.35	6.53	4.78	84	.00**

** p≤ .00, 1 tail Key: BDI= Beck Depression Inventory; STSS= Silencing the Self Scale; RAS= Relationship Assessment Scale; IAMW= Inventory of Attitude Toward Men and Women

Although it has been established that the two groups differ on the STSS, IAMW and RAS, the final link that needs to be established is whether these three measures also are related to depression, as measured by the BDI. A multiple regression was conducted with those variables (the STSS, IAMW and the RAS), which not only differentiated the Community and Clinic groups, but also demonstrated statistically significant relationships to the Beck Depression Inventory. The STSS and the RAS correlated significantly with the BDI. Substantively, these findings indicated that women who silenced themselves (Beta=.37, $p=.00$), and who were not satisfied with their intimate relationships (Beta = -.36, $p=.00$), were more likely to be depressed. The IAMW was not correlated with the BDI in the presence of the group variable (Beta =.05, $p=.29$) The STSS and the RAS are each related to group membership and each related to the difference in depression between the groups. The correlation between the STSS and BDI is .49 and the correlation between the RAS and the BDI is -.47. Thus, the STSS is significantly correlated with the BDI. Also, the RAS is inversely correlated to the BDI.

The conclusion of this analysis involves determining how much the STSS and the RAS are related to depression. Given that the linkage between the STSS and the RAS as covariates of group membership and depression has been established, then once the STSS and RAS are controlled, the differences between the groups should diminish. An analysis of covariance was conducted where the STSS and the RAS were used as covariates, and the two groups were compared on the BDI. Please refer to Table 11. Although the STSS and RAS scales are significantly related to depression, the differences in average levels of depression remain statistically

significant even after controlling for or removing the effects of the STSS and the RAS. However, the magnitude of the original difference between the 2 groups has been significantly reduced. Please refer to Table 12.

Table 11.

Comparison of groups on the BDI Analysis of Covariance					
Source Table					
Effects	Sum of Squares	DF	Mean Square	F	p
Covariates: STSS; RAS	125.31	2	562.65	6.97	.00
Group: Comm/Clinic	820.85	1	820.85	10.17	.00

Table 12.

Unadjusted and Adjusted Means Between Groups*

Group	Observed Means	Adjusted Means
Community	12.37	15.16
Clinic	25.78	22.98

*significant at p=.000, 1 tail

Specifically, the magnitude of the original difference between the 2 groups (25.77-12.36) equaling 13.41 points on the Beck Depression Inventory has been reduced to (22.98-15.16=) 7.82 points. To restate it another way, the difference between the groups on the Beck after controlling for the STSS and RAS is 42% smaller than the original difference. Therefore the difference between the two groups on the BDI diminishes, but it is not completely eliminated.

Summary These findings are consistent with the claim that the “silencing the self” as a basis for maintaining intimacy and relationship satisfaction, does play a major role in Latina depression, although they do not fully explain it. The IAMW was redundant with the RAS and the STSS. The findings do uphold the hypothesis that there is a significant positive correlation between the belief in sex roles and depression among Latina women. The findings do uphold the hypothesis that women who experience lower levels of relationship satisfaction will have higher levels of depression irrespective of their belief in traditional sex roles. The findings also uphold that the amount of education of Latina women will be negatively correlated with their beliefs in traditional marianismo sex roles for women, regardless of their level depression. In an analysis of covariance where age and marital status were used as covariates and the effects were eliminated the findings indicated that there still remained a statistical difference between the two groups on the BDI. In order to determine how of much the difference on the BDI was due to the STSS, RAS and IAMW a multiple regression was conducted. It was found that the STSS and the RAS correlated significantly on the BDI. An analysis of co-variance where the STSS and the RAS were factored out found that the original difference between the Community and the Clinic on the BDI was reduced by 42%. Therefore, the magnitude of the original difference between the 2 groups has been reduced, indicating that relationship satisfaction and silencing the self plays a major role in Latina depression.

Chapter 5

Discussion

This study explored the impact of women's adherence to traditional sex roles, relationship satisfaction and self-silencing and self-sacrificing behaviors within the context of an intimate relationship as a factor of depression in a sample of clinically depressed and "normal" Latina women. The main finding of this study is that regardless of age and marital status, women who either did not have a satisfactory relationship, and/or self-silenced and self-sacrificed in the context of an intimate relationship show consistently higher levels of depression. Other findings derived from the analysis of the hypotheses of the study are: (i) there is a positive correlation between traditional sex roles and depression in this group of women; (ii) there is a negative correlation between relationship satisfaction and depression; and (iii) there is an inverse relationship between education and belief in traditional marianismo attitudes. Depression was measured by the Beck Depression Inventory (BDI) and the Silencing the Self Scale (STSS), relationship satisfaction was measured by the Relationship Satisfaction Scale, traditional, marianismo, sex role was measured by the Inventory of Attitudes Towards Men and Women (IAMW). The subjects' educational level and other demographic data was obtained from the demographic questionnaire. All subjects were Latina women, born outside the US and had Spanish as their first language. Consequently, all measures were administered in Spanish. A little more than half were self-identified as depressed (Clinic group); the other half were selected from a community program that served a unselected population. The hypothesis was tested treating the sample as a whole. Further analysis involved comparing the two groups.

The results supported hypothesis #1 that there exists a significant correlation between the occurrence of belief in traditional marianismo sex roles and depression among this particular group of Latina women ($r = .19$). In using the BDI as the measure of depression, the hypothesis supported a relationship of weak strength. Morris & Fitzgibbons (1978) warns against attributing importance to a correlation within the weak range (absolute value of 0 to .20) unless the number of cases is several hundred. Therefore, the relationship between the BDI and the traditional marianismo sex roles is weak and suspect, given that the sample was under one hundred.

Previous studies have established a strong link between depression and belief in traditional sex roles (Sotos & Shaver, 1981; Torres Matrullo, 1976), with a measure of clinical depression, in the both studies, the measure of depression related to clusters of symptoms, (the former study used the Symptom Checklist and the latter study used the Wittenborn Psychiatric Scale). The present study provides support for a weak link between a clinical measure of depression (BDI) and traditional marianismo sex roles. The lack of support for a moderate or strong relationship between marianismo and the BDI as compared to previous study may be an result of the different instruments used in measuring depression.

However, in using the STSS as the measure of depression the results indicated a positive, significant relationship of moderate strength between traditional marianismo sex roles and depression ($r = .40$). This apparent difference in the strength of the relationship relates to the different aspect of depression being measured. The BDI measures symptoms and attitude of depression; whereas, the STSS measures

interpersonal aspects of depression. Specifically, it measures the beliefs women have about proscription governing their own behavior in order to maintain intimacy.

It makes intuitive sense that self-silencing, self-sacrificing is related to traditional marianismo sex roles when one considers that part of the marianista code involves self-suppression and the conscious control of negative emotions (Bracero, 1998, in press). To date there are no studies that relate silencing of the self theory to traditional marianismo sex roles in any ethnic group of women. In essence, the findings support the concept that marianismo and silencing of the self theory overlap where they both share self-silencing and self-sacrificing behaviors. However, there are many differences yet to be delineated that differentiate these concepts. A crucial difference lies in phenomenological experience of the images of the self in intimate relationships. Bracero (1998, in press) describes marianismo as involving a disconnection with the self arising from long tradition that dates back to early Christianity and the philosophy of Stoicism. Implicit in Bracero's description is a definition of self based on self-denial. Jack (1992) describes self-silencing as involving a loss of authentic connection with the self. The implication of these differences, where on the one hand, the self is based on the experience of denial for the greater good, and on the other hand where loss is a condition implicit to the maintenance of intimacy needs further study. Moreover, the implication of these differences as they relate to depression need to be examined.

The results supported the hypothesis #2 that stated that women who have lower levels of relationship satisfaction will have higher levels of depression, regardless of their belief in traditional marianismo sex roles. This was borne out both in the

analysis where the sample was treated as one, and also, where the analysis differentiated between the Clinical and Community groups. The analysis of the entire sample yielded a result of $r = -.47$, indicating a moderate negative relationship between the RAS and the BDI.

In the case where the STSS was used as the measure of depression, the correlation between the STSS and the RAS is $r = -.28$, indicating a negative, statistically significant relationship. In comparing this result with that which utilized the BDI as the measure of depression, it is evident that silencing the self and relationship satisfaction are correlated, but not as strongly as silencing the self with a measure of clinical depression. Taken together, however, it is found that the RAS is inversely correlated with the STSS and the BDI. This finding indicates that relationship satisfaction is related to beliefs about intimacy and affective state.

In a related study, Thompson (1995) compared couples to examine the relationship between marital adjustment, as measured by the Dyadic Adjustment Scale and the STSS. The author found an inverse relationship of moderate strength, $r = -.53$. The findings of the present study, although significant, are weaker than those obtained by Thompson. One factor may have to do with the Relationship Assessment Scale (RAS) with 7 items, being a global measure of relationship satisfaction; whereas, the Dyadic Adjustment Scale, with 32 items, operationalizes the actual behaviors that relate to intimacy.

The findings from the present study conform to the expectation that a confiding intimate relationship has a protective factor in mediating depression in women, even in the face of hardship, such as poverty, having young children and

illness (Brown and Harris, 1986). Such factors concerning this population include a low rate of employment and relative low level of educational attainment. Although the study presented here, cannot confirm with any certainty whether lack of relationship satisfaction is a result or a precipitant of depression, other studies have established that marital maladjustment is more likely to be a precipitant to depression than to have been caused by it (Dobson, 1987; Birtchnell and Kennard, 1983). In another study, Brown et al. (1986) found that lack of support from a core relationship, defined as a lover or husband, at a time of crisis led to a high risk of depression.

The saliency of the finding confirms that the self is, at its core, relational and that depression from a relational perspective is failure of connection. As Jack states (1992), depression is *interpersonal*. The findings also confirm the centrality of relationship to women's depression.

Given the significant finding, and that the Relationship Assessment Scale is a relatively new measure, which to date has not been correlated with a measure of depression, it is an effective instrument in measuring global relationship satisfaction. In addition, in this study the RAS has been successfully applied to a Latino population extending its application to be used cross-culturally with this population.

The results supported the hypothesis #3 that the level of education will be inversely correlated with beliefs in traditional sex roles. This confirms that the level of education influences the attitudes one has about gender roles, and it certainly makes intuitive sense if one considers that as one's knowledge, concepts and understanding of the world broadens so does one's sense of agency or mastery (McGrath, et al.1990). In the study presented here, $r = -.30$ was obtained, indicating a weak

negative correlation. This relative low absolute value may relate to the fact that the sample did not represent the highest educational levels since only seven women from the Community and none from the Clinic group attended college. The mean educational level for the Community sample was tenth grade, while for the Clinic sample it was ninth grade. Nevertheless, statistical significance was achieved within the range sampled such as those that attained the highest level of education had the lowest belief in traditional sex roles.

Torres-Matrullo (1976) examined the relationship between sex role attitude with acculturation, and found that sex role attitude remains basically the same across a spectrum of high and low acculturated subjects, but that education was found to be an important variable influencing difference in sex role attitude change. The results from this study demonstrate that education, plays a role in exposing women to less traditional norms and behaviors.

Although the hypothesis do not examine the relationship between the STSS and BDI it is included in the scope of this study. The correlation of the STSS and the BDI obtained in this study ($r = .49$) is considered of moderate strength. This finding is similar to those obtained in previous studies by Jack and Dill (1992), Thompson (1995), Vaden Gratch, Basset and Attra, (1995). In the first of these studies, the authors analyzed three distinct samples of women: non-depressed, mildly depressed and moderately depressed, where correlation coefficient were respectively .52, .51, .50. However, this study had only 2.2% of the sample self-identified as Hispanic. In the Thompson study, a correlation of $r = .63$. was obtained. In the second study, Vaden Gratch, et al. (1995) examined the relationship of gender and ethnicity to self-

silencing and depression, where Asians, Asians Americans, Hispanics, African Americans and Caucasians college students were compared on the BDI and the STSS. The results indicated an $r = .59$ among Hispanic women. The present study differs from the Gratch et al. (1995) in that it used women representative of an urban community as opposed to a suburban college population. The study provides confirmation of the correlation of the STSS with the BDI for a Latino population

The second way, and more powerful method of analyzing the data, is to compare the groups and determine the degree to which the STSS, RAS and the IAMW is implicated in the women's scores on the BDI. However, first several criterion had to be met. A t- test confirmed that the groups differed significantly on their mean scores for the BDI. This was further confirmed by a correlation coefficient of $r = .58$ that confers to the relationship between group membership and depression statistical significance of moderate strength. In examining the data in this way, where the sample is differentiated between clinically depressed and non-depressed, the positive findings are still supported.

It was also determined that the groups differed on various other demographic variables. In terms of country of origin, a preponderance of the women of the Clinic came from Puerto Rico (68.9%) with the next ranking being the Dominican Republic (22.2%). By contrast, the Community only had one substantial cluster represented by Mexico (34.1%). Interestingly, the Clinic had no women from Mexico. This disparity may be explained by the fact that Puerto Ricans, as US citizens, are entitled to government benefit that allow them to access to mental health services. Additionally, significant immigration from Mexico to this region is a more recent phenomenon, as

such members from this group may be marginalized by not having legal status and therefore, limited access to mental health services.

A Chi Square Analysis determined that the Clinic sample is less likely to be working than the Community sample. However, only 14% of the combined sample of women have a job. There are a multitude of global factors that account for the unemployment of the sample, and primary among them are the lack of jobs (more acutely in the unskilled sector than skilled sector) that coupled with the low educational level, ergo, low level of job skills. However, other consequent factors are this population's limited English proficiency and their legal status regarding immigration, both acting synergistically and independently in barring some types of employment. From a different perspective, 14% reflects only employment and does not reveal whether women may be under-employed. Women from this sample may engage in work where they are marginally remunerated. Even if a substantial number of women are under-employed, it would not impact on the results of the study.

The finding that 100% of the Clinic group has had psychotherapy, while only 7% of the Community group has had psychotherapy is not surprising. The Clinic group was selected on the basis of their being treated for depression; whereas, the Community group was not selected on any criterion.

The findings that the Clinic group has been in the US three times as many years as the Community groups may relate to the country of origin. The Clinic group is 68.9% from Puerto Rico and this ethnic group has a longer history of migration to this region. The Clinic average level of education is somewhat less than the Community, ninth grade vs. tenth grade. While the difference is significant, it is not a

relevant finding for depression. The Clinic group has significantly more children than the Community group; however, with an average age of 33, the Community group is still within childbearing years, whereas the Clinic group with the average age of 50 is not.

With respect to marital status, the women from the Clinic were more likely to not have a partner. This makes intuitive sense given women's relational orientation. As Kaplan (1986) notes, when relationship disruption occurs it is more likely to be experienced more centrally as a failure of the self. Brown et al. (1986) found that when women are let down by a core relational tie, they are more likely to become depressed. Therefore, disruption in relationship status may result in an increase in help-seeking behavior.

The groups did not differ in the number of years living with a partner. The women from the Community group lived with partners a average of 2.3 vs.1.8 for the Clinic. Taken as a whole, this sample of women may experience more stress associated with poverty, acculturation, low levels of education that may impair ability to sustain relationships and which would account for the short duration of an intimate relationship. In addition, it is possible that personality factors are influenced by the above-mentioned stressors and affect the ability to sustain relationships. For instance, the Brown and Harris (1986) study found that lack of social support and low self-esteem contribute over time to depression. The women in this sample may lack the ability to sustain relationships because of a multiplicity of factors, poverty and acculturative stress affecting self esteem and consequently their ability to sustain relationships

In examining age, a t-test indicated that the Clinic group is nearly 18 years older on average than the Community group. Although rates of depression have been reported as remaining stable or decreasing with age (Nolem-Hoeksema, 1990), it is possible that other factors that pertain to this sample are involved. In this regard, McGrath et al. (1990) reported that depression in older women is associated with poverty and most of the women in this sample are poor, given the low rates of employment.

Notwithstanding the significant differences between the groups on these demographic variables, a stepwise multiple regression determined that only age and marital status are of consequence to depression. However, in conducting an analysis of variance where age and marital status were factored out, the difference on the BDI failed to change, demonstrating that the difference between the groups are due to other factors. In fact, there is virtually no adjustment on the BDI scores, where the original difference between the groups on the BDI was reduced by only .64.

Further analysis found that the two groups, the Clinic and the Community, differed significantly on the IAMW, the RAS and the STSS. The Clinic group displays a greater tendency to silence the self, to believe in traditional sex roles for men and women and to be less satisfied in their relationship. However, a subsequent multiple regression determined that only the STSS and the RAS were related to depression. In effect, women from the Clinic have a greater tendency to silence themselves and have lower levels of relationship satisfaction. This study found that silencing of the self in intimate relationship and low levels relationship satisfaction account for 42% of the difference between the Clinic and the Community on depression as determined by the

BDI. While the difference between the groups on the BDI remains statistically significant, it is evident that the finding that satisfaction in intimate relationships and self silencing in the context of intimate relationship accounts for almost half of the difference in depression between the two groups.

The implication of the finding is that silencing of the self and relationship satisfaction are related to depression in Latina women. Moreover, women's inherent relational orientation may put them at risk for depression. Understanding the social context becomes crucial in understanding the factors affecting depression.

Taken together, the findings from this study demonstrate that silencing the self and relationship satisfaction are important components of depression in Latinas. The impact of these two components on depression for Latinas is evident by the magnitude of this effect. These results contribute to our understanding of depression among Latinas.

Limitations of the study:

These findings need to be interpreted with consideration of a number of methodological limitations. First, the subjects in this study were homogeneous in many of their demographic characteristics. For example, the majority of the subjects were unemployed, had relatively low levels of education, and lived in poverty. This limits the degree to which the results could be extended. Also, the subjects were homogeneous in that they were all immigrants which may have resulted in there being little variation on the measure of traditional gender roles. Also, given that these women are immigrants, a measure of acculturation may have shed more light on the relationship these women have to their host country and how that in turn affects

depression and the interaction of the other variables.

Paradoxically, the sample may have been too heterogeneous in terms of country of origin. This resulted in a polarity where the majority of the Clinic group consisted of women from Puerto Rico, while the majority of the Community group consisted of women from Mexico. The net effect of this bifurcated cultural difference on outcome variables is difficult to calibrate with certainty.

Second, another limitation is the measure of traditional marianismo sex roles used in this study. The IAMW was not intended as a measure of marianismo *per se*. Although marianismo relates to traditional sex roles, it is not equivalent to sex roles.

Third, when interpreting the results, it is important to be mindful of not making any causal statements. It is impossible to determine whether silencing precedes depression or vice versa. Similarly, it is not known whether women's silencing precedes relationship satisfaction or vice versa. Only longitudinal studies can clarify these issues.

Recommendations for further research

To date there is no measure in the field to capture the constellation of behaviors and attitudes related to marianismo; as a result there has been scant research in the area. Vazquez & Gil (1996) emphasized that a major component of psychotherapy for Latinas was to consider the impact of marianismo, "since it seems to cause variations in behavior and development which require special understanding on the part of the therapist." Therefore, objective indices need to be developed in order to facilitate understanding of this phenomenon

This study looked at relationship satisfaction as it relates to depression. Further study should explore the role of mutuality in relationship satisfaction; and examine the ways that both of these variables relate to depression in women. Mutuality is a component of intimacy that may have a more direct bearing on depression than a global measure of relationship satisfaction. In addition, the manner in which these variables, of relationship satisfaction and mutuality are embedded in a cultural context should be explored. For instance, Garcia-Coll (1995), who draws upon her experience of being nurtured in a large traditional Puerto Rican family, observes that relationships were not equal and yet growth enhancing. She observes that mutuality does not imply equality, and questions whether one can attain mutuality within traditional cultural patterns of hierarchical relationships. An exploration of these questions would provide some objective indices to better examine the factors that constitute relationship satisfaction that mediate depression specific to Latinas.

Finally, this study documents the deleterious effects of not having a voice within the context of an intimate relationship for Latinas. The construct of voice is a powerful tool in describing women's psychological development, and this may be because, as the social psychologist Shulamite Reinharz (1992) observes, people struggling to overcome oppression use voice as a metaphor because it is active, while other images, such as writing and vision are passive. Having voice in the context of an intimate relationship needs to be explored. In addition, it would be fruitful to examine what it means to have a voice within a relationship embedded within a particular cultural context.

Summary and conclusions:

This study explored the impact of women's adherence to traditional sex roles, relationship satisfaction and self-silencing and self-sacrificing behaviors within the context of an intimate relationship as a factor of depression in a sample of clinically depressed and "normal" Latina women. The study examined the correlation between traditional sex roles and depression. The study also evaluated the relationship of both relationship satisfaction and education to depression. Additionally, it explored the role of self-silencing and self-sacrificing behavior on depression.

The sample was composed of 86 Latina women. Forty of the women were recruited at a community center; forty-six were recruited from a mental health clinic. The women from the Clinic were diagnosed as depressed and receiving treatment for depression. All recruitment was on a voluntary basis. Analysis of the hypothesis were conducted in two different ways by treating the sample as a whole, and also by comparing the two groups: Community and the Clinic.

To establish these findings, depression was measured by the *Beck Depression Inventory* (BDI), and the *Silencing the Self Scale* (STSS), relationship satisfaction was measured by the *Relationship Assessment Scale* (RAS), traditional marianismo sex roles was measured by Coles' *Inventory of Attitude towards Men and Women* (IAMW), and the educational level was obtained from the demographic questionnaire, and corresponded to the highest educational attainment level.

In comparing the samples it was found that the groups differed on a number of demographic variables. In terms of country of origin, the Clinic groups was predominantly from Puerto Rico, 68.9%, whereas the Community group was from

Mexico (34.1%). The Clinic sample was less likely to be working than the Community sample. However, only 14% of the entire sample was employed. The Clinic group was in the US three times as many years than the Community group. The Clinic's average level of education is somewhat less than the Community's, ninth grade vs. tenth, while the difference is significant it is not a relevant finding for depression. The Clinic group has significantly more children than the Community, 3 vs. 2, and this may be related to the difference in age between the groups. This may also be related to age, where the Clinic group is significantly older than the Community group, by average of 18 years. The women from the Clinic were less likely to have a partner than the Community group. Although age and marital status were the only two demographic variables related to depression, an analysis of covariance indicated that the difference between the two groups, after controlling for age and marital status, on the BDI was still significant.

In treating the entire sample, the results of correlational analysis indicated that there was significant relationship between traditional sex roles and depression in this group of women. There is a significant moderate inverse relationship between relationship satisfaction and depression.

Based on the findings of this study, and with consideration of its limitation, the following conclusions are considered tenable:

- (1) Regardless of age and marital status women who either did not have a satisfactory relationship, and or/ self silenced and self-sacrificed in the context of an intimate relationship show consistently higher levels of depression.

- (2) There is a significant relationship between traditional sex roles and depression in this group of women.
- (3) There is a negative relationship between relationship satisfaction and depression
- (4) There is an inverse relationship between education and belief in traditional sex roles

Final Comment

The findings illustrate that silencing the self is exacerbated by the centrality of relationship to women's identity and that women self-silence in order to maintain intimacy resulting in depression. For Latina women, the social construction of gender beliefs overlap with cultural marianismo beliefs that delineate ideals of self-suppression and self-sacrifice. The adherence to the marianista code involves disconnection; Silencing the self implies a loss of authentic connection with the self. The implication for treating depression in Latinas is to carefully listen to their own narratives for the disjuncture where the culture or the gender intercede and replace silence for women's voices.

Appendix A

Dear Participant,

I would like you to participate in research project that will explore the thoughts and feelings of Latina women. The purpose of the project is to gain a better understanding about the issues that Latina women face in their lives. All you need to do is to fill out 4 separate questionnaires that will not take more than one hour of your time.

Your participation is completely voluntary and you will be free to refuse or stop at any time. There are no foreseeable risks or benefits. There is no penalty if you choose not to participate. All information is confidential and you will not even have to reveal your name.

If your are interested, you will be provided with a summary of the research study once it is completed. Please indicate below your mailing address, if you want these results sent to you.

Sincerely,

Maria D. Vazquez M.S.
Graduate Student
Clinical Psychology, City College

_ I have read and understand the consent letter. I give consent to participate in the study.

Signature/date _____

I will like to have a summary of the research sent to me at the address listed below

Estimada participante:

Me gustaria obtener su participacion en un proyecto para investigar los pensamientos y sentimientos de las mujeres latinas. El proposito de este proyecto es obtener un mejor entendimiento de los problemas que las mujeres latinas afrontan en sus vidas. Todo lo que usted tiene que hacer es rellenar cuatro cuestionarios, lo que no le ocupara mas de una hora.

Su participacion es totalmente voluntaria y usted tiene libertad para no continuar en cualquier momento. No se esperan riesgo o beneficios de su participacion. No existe ninguna penalidad si decide no participar. Toda la informacion es confidencial y usted no tiene ni siquiera que dar su nombre.

Si lo desea, una vez que el estudio se haya completado, le entregare un resumen con las conclusiones obtenidas. Por favor, indique al final de esta pagina la direccion si quiere el resumen.

Atentamente,

Maria D. Vazquez M.S.
Estudiante de Doctorado
Psicologia clinica, City College

He leído y entiendo la carta de consentimiento. Doy mi consentimiento a participar en el estudio.

Firma/Fecha _____

Me gustaria recibir una copia del resumen del trabajo. Por favor, enviemelo a la siguiente direccion:

Appendix B

Demographic Questionnaire

1) Marital Status:

- single
- married or living with partner
- separated
- divorced
- widowed
- other

2) If you are presently living with your husband or partner check off the items that indicate the number of years you are living together

___ under 1 year; ___ 1-5 years; ___ 5-10 years; ___ over 10 years

3) Indicate your country of origin or the ethnic background that describes you by checking the appropriate item.

- ___ Puerto Rico
- ___ Dominican Republic
- ___ Cuba
- ___ Columbia
- ___ Mexico
- ___ El Salvador
- ___ Other (please specify country) _____

4) Please indicate your year of birth _____

5) Educational Background : Please indicate the last year of school that you attended

- | | |
|-------------------------------|-----------------------|
| Less than the 9th grade _____ | College 1 year _____ |
| 9th grade _____ | 2 years _____ |
| 10th grade _____ | 3 years _____ |
| 11th grade _____ | 4 years _____ |
| 12th grade _____ | Graduate school _____ |

6) Are you working? Yes _____ No _____
Occupation _____

7) Please Indicate how many children you have _____

8) Have you had psychotherapy? Yes _____ No _____

Appendix C

THE SILENCING THE SELF SCALE

Please circle the numbers that best describe how you feel about each of the statements below.

STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEITHER NOR DISAGREE	AGREE	SOMEWHAT AGREE	STRONGLY AGREE
1	2	3		4	5

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 other 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

STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEITHER NOR DISAGREE	AGREE	SOMEWHAT AGREE	STRONGLY AGREE
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

STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEITHER NOR DISAGREE	AGREE	SOMEWHAT AGREE	STRONGLY AGREE
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 if certain of my need 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

STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEITHER NOR DISAGREE	AGREE	SOMEWHAT AGREE	STRONGLY AGREE
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 feeling.

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 relationships (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

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

1 2 3 4 5

LA ESCALA CALLANDO EL YO

Por favor, haga un circulo alrededor del numero que mejor describa como se siente usted acerca de cada una de las oraciones aqui enumeradas.

FUERTEMENTE EN DESACUERDO	ALGO EN DESACUERDO	NI DE ACUERDO NI EN DESACUERDO	ALGO DE ACUERDO	FUERTEMENTE DE ACUERDO
1	2	3	4	5

1. Pienso que es mejor cuidar de mi primero porque nadie mas va a velar por mi.

1 2 3 4 5

2. No expreso mis sentimientos en una relacion intima cuando se que estos causaran un desacuerdo.

1 2 3 4 5

3. Preocuparse significa poner las necesidades de la otra persona primero que las mias.

1 2 3 4 5

4. Es egoista considerar que mis necesidades sean tan importante como las de aquellos a quienes amo.

1 2 3 4 5

5. Encuentro que me es mas dificil ser yo misma cuando estoy en una relacion intima, que cuando estoy sola.

1 2 3 4 5

6. Tiendo a juzgarme de acuerdo a la manera en que yo pienso que otras personas me ven.

1 2 3 4 5

FUERTEMENTE EN DESACUERDO	ALGO EN DESACUERDO	NI DE ACUERDO NI EN DESACUERDO	ALGO DE ACUERDO	FUERTEMENTE DE ACUERDO
1	2	3	4	5

7. Me siento insatisfecha conmigo misma porque yo debería poder hacer todas las cosas que la gente esta supuesta a poder hacer hoy en día.

1 2 3 4 5

8. Cuando los sentimientos y las necesidades de mi pareja confligen con los míos, yo siempre expreso los míos claramente.

1 2 3 4 5

9. En una relación íntima, mi responsabilidad es hacer feliz a la otra persona.

1 2 3 4 5

10. Preocuparse significa elegir hacer lo que la otra persona quiere, aun cuando yo quiera hacer algo diferente.

1 2 3 4 5

11. Para sentirme bien conmigo misma, yo necesito sentirme independiente y auto-suficiente.

1 2 3 4 5

12. Una de las peores cosas que yo puedo hacer es ser egoísta.

1 2 3 4 5

13. Siento que debo actuar de cierta manera para complacer a mi pareja.

1 2 3 4 5

14. En lugar de arriesgarme a tener confrontaciones en relaciones íntimas, yo prefiero dejar las cosas como están.

1 2 3 4 5

FUERTEMENTE EN DESACUERDO	ALGO EN DESACUERDO	NI DE ACUERDO NI EN DESACUERDO	ALGO DE ACUERDO	FUERTEMENTE DE ACUERDO
1	2	3	4	5

15. Hablo de mis sentimientos con mi pareja, aun cuando estos me lleven a tener problemas o desacuerdos.

1 2 3 4 5

16. A menudo me veo contenta por fuera, pero por dentro me siento enfadada y rebelde.

1 2 3 4 5

17. Para que mi pareja me ame, yo no le puedo revelar ciertas cosas acerca de mi misma.

1 2 3 4 5

18. Cuando las necesidades u opiniones de mi pareja confligen con las mias, en lugar de hacer valer mi punto de vista, usualmente, termino concordando con el/ella.

1 2 3 4 5

19. Cuando estoy en una relacion intima, yo pierdo la nocion de quien soy.

1 2 3 4 5

20. Cuando parece que algunas de mis necesidades no seran realizadas en una relacion intima, usualmente me doy cuenta de que comoquiera estas no eran importantes.

1 2 3 4 5

21. Mi pareja, me ama y me aprecia por quien yo soy.

1 2 3 4 5

22. Hacer cosas solo para mi misma es ser egoista.

1 2 3 4 5

FUERTEMENTE EN DESACUERDO	ALGO EN DESACUERDO	NI DE ACUERDO NI EN DESACUERDO	ALGO DE ACUERDO	FUERTEMENTE DE ACUERDO
1	2	3	4	5

23. Cuando tomo decisiones, me dejo influenciar por los pensamientos y opiniones de los demas, mas que por mis propios pensamientos y opiniones.

1 2 3 4 5

24. Raramente expreso mi enojo a aquellos cerca de mi.

1 2 3 4 5

25. Siento que mi pareja no conoce mi verdadero yo.

1 2 3 4 5

26. Pienso que es preferible reservarme mis sentimientos cuando estos confligen con los de mi pareja.

1 2 3 4 5

27. A menudo me siento responsable por los sentimientos de los demas.

1 2 3 4 5

28. Encuentro dificil saber que es lo que yo pienso y siento porque paso mucho tiempo pensando en como la otra gente se siente.

1 2 3 4 5

29. En una relacion intima, usualmente no me importa lo que hagamos, siempre y cuando la otra persona este contenta.

1 2 3 4 5

30. Trato de esconder mis sentimientos cuando pienso que estos pueden causarme problemas en mi(s) relacion(es) intima(s).

1 2 3 4 5

FUERTEMENTE EN DESACUERDO	ALGO EN DESACUERDO	NI DE ACUERDO NI EN DESACUERDO	ALGO DE ACUERDO	FUERTEMENTE DE ACUERDO
1	2	3	4	5

31. Parece que nunca igualo las expectativas/metras que me fijo para mi misma.

1	2	3	4	5
---	---	---	---	---

32. Si usted circulo el numero 4 o 5 en la ultima pregunta, entonces, escriba por lo menos tres de las expectativas/normas que usted siente que nunca puede igualar.

1	2	3	4	5
---	---	---	---	---

APPENDIX D

INVENTARIO DE BECK

NOMBRE _____

FECHA _____

En este cuestionario hay grupos de afirmaciones. Por favor, lea cuidadosamente cada grupo de afirmaciones. Escoja la afirmacion de cada grupo que mejor describa la manera en la que se ha sentido la **SEMANA PASADA, INCLUYENDO HOY**. Circule el numero al lado de la afirmacion seleccionada. Si varias afirmaciones en el grupo parecen aplicar igualmente, circule cada una. Asegurese de leer todas las afirmaciones en cada grupo antes de hacer su seleccion.

- | | | |
|---|---|--|
| 1 | 0 | No me siento triste. |
| | 1 | me siento triste. |
| | 2 | me siento triste todo el tiempo y no puedo dejar de estarlo. |
| | 3 | me siento tan triste o infeliz que no puedo soportarlo. |
| 2 | 0 | No me siento particularmente desanimado(a) acerca del futuro. |
| | 1 | Me siento desanimado(a) acerca del futuro. |
| | 2 | Siento no tener razon para mirar hacia adelante. |
| | 3 | Siento que el futuro es desesperanzador y que las cosas no pueden mejorar. |
| 3 | 0 | No me siento como un(a) fracasado(a). |
| | 1 | Siento que he fracasado mas que la persona promedio. |
| | 2 | Cuando miro hacia atras en mi vida, todo lo que puedo ver son fracasos. |
| | 3 | Siento que soy un fracaso total como persona. |
| 4 | 0 | Obtengo tanta satisfaccion de las cosas como acostumbraba. |
| | 1 | No disfruto las cosas de la manera que acostumbraba. |
| | 2 | Ya no obtengo satisfaccion real de las cosas. |
| | 3 | Estoy insatisfecho(a) o aburrido(a) de todo. |
| 5 | 0 | No me siento particularmente culpable. |
| | 1 | Me siento culpable gran parte del tiempo. |
| | 2 | Me siento bastante culpable la mayor parte del tiempo. |
| | 3 | Me siento culpable todo el tiempo. |

- 6 0 No siento que me castigan.
 1 Siento que puedo ser castigado(a).
 2 Espero ser castigado(a).
 3 Siento que me castigan.
- 7 0 No me siento decepcionado(a) conmigo mismo(a).
 1 Estoy decepcionado(a) conmigo mismo(a).
 2 Estoy asqueado(a) conmigo mismo(a).
 3 Me odio.
- 8 0 No siento que soy peor que cualquier otro(a).
 1 Me critico por mis debilidades o errores.
 2 Me culpo todo el tiempo por mis faltas.
 3 Me culpo por todo lo malo que sucede.
- 9 0 No he pensado en matarme.
 1 He pensado en matarme, pero no lo haria.
 2 Desearia matarme.
 3 Me mataria si tuviera la oportunidad.
- 10 0 No lloro mas de lo usual.
 1 Ahora lloro mas que lo acostumbrado.
 2 Ahora lloro todo el tiempo.
 3 Antes podia llorar, pero ahora no puedo, aunque quiera.
- 11 0 No estoy mas irritado(a) de lo que siempre estoy.
 1 Me molesto o irrito con mas facilidad que lo acostumbrado.
 2 Ahora me siento irritado(a) todo el tiempo.
 3 No me irritan en absoluto las cosas que acostumbradan irritarme.
- 12 0 No he perdido interes en otra gente.
 1 Estoy menos interesado(a) en otra gente de lo que acostumbraba a estar.
 2 He perdido la mayor parte de mi interes en la otra gente.
 3 He perdido todo mi interes en otra gente.
- 13 0 Tomo decisiones como lo he hecho siempre.
 1 Pospongo mas que antes el tomar decisiones.

- 2 Tengo mas dificultad que antes en la toma de decisiones.
3 Ya no puedo tomar decisiones.
- 14 0 No siento que luzco peor que antes.
1 Me preocupa lucir como un(a) viejo(a) sin atractivo.
2 Siento que hay cambios permanentes en mi apariencia que me hacen lucir sin atractivo.
3 Creo que me veo feo(a).
- 15 0 Puedo trabajar tan bien como antes.
1 Requiere un esfuerzo adicional al hacer algo.
2 Tengo que obligarme mucho para cualquier cosa.
3 No puedo hacer ningun trabajo.
- 16 0 Puedo dormir tan bien como acostumbro.
1 No duermo tan bien como acostumbraba.
2 Me despierto una o dos horas antes de lo usual y se me hace dificil volver a dormir.
3 Me despierto varias horas antes de lo acostumbrado y no puedo volver a dormir.
- 17 0 No me canso mas de lo usual.
1 Me canso con mas facilidad que antes.
2 Me canso de hacer casi cualquier cosa.
3 Estoy demasiado cansado(a) para hacer cualquier cosa.
- 18 0 Mi apetito no ha disminuido.
1 Mi apetito no es tanto como antes.
2 Ahora tengo mucho menos apetito.
3 Ya no tengo apetito.
- 19 0 No he perdido mucho peso, si alguno ultimamente.
1 He perdido mas de 5 libras.
2 He perdido mas de 10 libras.
3 He perdido mas de 15 libras.
- 20 0 No estoy mas preocupado(a) por mi salud que lo usual.
1 Estoy preocupado(a) por mis problemas fisicos, como dolores, malestar estomacal o estrenimento.

- 2 Estoy muy preocupado(a) por mis problemas fisicos, y es
deficil pensar en otra cosa.
- 3 Estoy tan preocupado(a) por mir fisicos, que no puedo pensar en
otra cosa.
- 21 0 No he notado ningun cambio reciente en mi interes por el sexo.
- 1 Estoy menos interesado(a) por el sexo que lo que acostumbraba.
- 2 Estoy mucho menos interesado por el sexo ahora.
- 3 He perdido totalmente el interes por el sexo.

APPENDIX E

INSTRUCCIONES

Este inventario esta compuesto de una serie de declaraciones que describen las actitudes y creencias que tienen diferentes personas sobre el papel que juegan las mujeres y los hombres en la sociedad. Conteste lo que mejor describa lo que usted piensa de cada una de ellas. Conteste Todas Las Declaraciones aunque no este seguro de su contestacion.

- ___ 1) Completamente de acuerdo: indique esta contestacion si la declaracion caracteriza sus actividades y creencias definitivamente.

- ___ 2) Bastante de acuerdo: indique esta contestacion si la declaracion describe sus creencias y actitudes moderadamente.

- ___ 3) Levemente de acuerdo: indique esta contestacion si la declaracion describe sus creencias y actitudes levemente.

- ___ 4) Levemente en desacuerdo: indique esta contestacion si la declaracion describe unas actitudes y creencias en maneras levemente contraria a sus opiniones.

- ___ 5) Bastante en desacuerdo: indique esta contestacion si la declaracion describe unas creencias y actitudes bastante contrarias a las suyas pero no completamente.

- ___ 6) Completamente en desacuerdo: indique esta contestacion si la declaracion describe unas creencias y actitudes completa y claramente contrarias a las suyas.

1. Es justo pedirle a un hombre que trabaja que ayude en las tareas de la casa.
 - a. Completamente de acuerdo
 - b. Bastante de acuerdo
 - c. Levemente de acuerdo
 - d. Levemente en desacuerdo
 - e. Bastante en desacuerdo
 - f. Completamente en desacuerdo

2. En general, los hombres son mas inteligentes que las mujeres.
 - a. Completamente de acuerdo
 - b. Bastante de acuerdo
 - c. Levemente de acuerdo
 - d. Levemente en desacuerdo
 - e. Bastante en desacuerdo
 - f. Completamente en desacuerdo

3. El exito de la mujer como madre es la mejor medida de como de buena mujer es.
 - a. Completamente de acuerdo
 - b. Bastante de acuerdo
 - c. Levemente de acuerdo
 - d. Levemente en desacuerdo
 - e. Bastante en desacuerdo
 - f. Completamente en desacuerdo

4. Una mujer puede ocupar el puesto de Presidente de los Estados Unidos tan bien como un hombre.
 - a. Completamente de acuerdo
 - b. Bastante de acuerdo
 - c. Levemente de acuerdo
 - d. Levemente en desacuerdo
 - e. Bastante en desacuerdo
 - f. Completamente en desacuerdo

5. Si fuera necesario un reclutamiento nacional las mujeres debieran ser reclutadas al igual que los hombres.
 - a. Completamente de acuerdo
 - b. Bastante de acuerdo
 - c. Levemente de acuerdo

- d. Levemente en desacuerdo
 e. Bastante en desacuerdo
 f. Completamente en desacuerdo
6. Considero aceptable el que una mujer acompañe a un hombre a su apartamento incluso a la noche.
- a. Completamente de acuerdo
 b. Bastante de acuerdo
 c. Levemente de acuerdo
 d. Levemente en desacuerdo
 e. Bastante en desacuerdo
 f. Completamente en desacuerdo
7. La mujer, por su naturaleza, está más interesada en las cosas de la casa que el hombre.
- a. Completamente de acuerdo
 b. Bastante de acuerdo
 c. Levemente de acuerdo
 d. Levemente en desacuerdo
 e. Bastante en desacuerdo
 f. Completamente en desacuerdo
8. Una mujer puede sentirse feliz y que vive una vida plena aunque nunca se case.
- a. Completamente de acuerdo
 b. Bastante de acuerdo
 c. Levemente de acuerdo
 d. Levemente en desacuerdo
 e. Bastante en desacuerdo
 f. Completamente en desacuerdo
9. Aun cuando tanto la mujer como el marido trabajen fuera es a la mujer a quien le toca estar encargada de la cocina.
- a. Completamente de acuerdo
 b. Bastante de acuerdo
 c. Levemente de acuerdo
 d. Levemente en desacuerdo
 e. Bastante en desacuerdo
 f. Completamente en desacuerdo

10. Los hombres no deben encargarse de la crianza de los hijos porque carecen de un instinto maternal.

- a. Completamente de acuerdo
- b. Bastante de acuerdo
- c. Levemente de acuerdo
- d. Levemente en desacuerdo
- e. Bastante en desacuerdo
- f. Completamente en desacuerdo

11. El cuidado del hogar es primordialmente responsabilidad de la mujer.

- a. Completamente de acuerdo
- b. Bastante de acuerdo
- c. Levemente de acuerdo
- d. Levemente en desacuerdo
- e. Bastante en desacuerdo
- f. Completamente en desacuerdo

12. No hay nada malo en regalarle muñecas a los niños varones.

- a. Completamente de acuerdo
- b. Bastante de acuerdo
- c. Levemente de acuerdo
- d. Levemente en desacuerdo
- e. Bastante en desacuerdo
- f. Completamente en desacuerdo

13. El hombre siempre debe tener más libertad, poder y privilegios que la mujer.

- a. Completamente de acuerdo
- b. Bastante de acuerdo
- c. Levemente de acuerdo
- d. Levemente en desacuerdo
- e. Bastante en desacuerdo
- f. Completamente en desacuerdo

14. La mujer, si trabaja afuera, no debe tener que estar encargada de ocuparse de los niños ella sola.

- a. Completamente de acuerdo
- b. Bastante de acuerdo
- c. Levemente de acuerdo
- d. Levemente en desacuerdo
- e. Bastante en desacuerdo

- f. Completamente en desacuerdo
15. Las mujeres no tienen que guardar su virginidad más de lo que cuidan su virginidad los hombres.
- a. Completamente de acuerdo
 b. Bastante de acuerdo
 c. Levemente de acuerdo
 d. Levemente en desacuerdo
 e. Bastante en desacuerdo
 f. Completamente en desacuerdo
16. Está perfectamente bien que un hombre le permita a una mujer pagar el taxi, comprar taquillas o pagar la cuenta.
- a. Completamente de acuerdo
 b. Bastante de acuerdo
 c. Levemente de acuerdo
 d. Levemente en desacuerdo
 e. Bastante en desacuerdo
 f. Completamente en desacuerdo
17. Algunas ocupaciones provocan una cantidad de tensión emocional tan grande que no se le pueden dar a las mujeres.
- a. Completamente de acuerdo
 b. Bastante de acuerdo
 c. Levemente de acuerdo
 d. Levemente en desacuerdo
 e. Bastante en desacuerdo
 f. Completamente en desacuerdo
18. Una mujer puede vivir una vida feliz y plena aun cuando no tenga hijos.
- a. Completamente de acuerdo
 b. Bastante de acuerdo
 c. Levemente de acuerdo
 d. Levemente en desacuerdo
 e. Bastante en desacuerdo
 f. Completamente en desacuerdo
19. El rol tradicional de la mujer de esposa y madre conlleva una restricción contraria a sus energías y visión.
- a. Completamente de acuerdo
 b. Bastante de acuerdo

- c. Levemente de acuerdo
 - d. Levemente en desacuerdo
 - e. Bastante en desacuerdo
 - f. Completamente en desacuerdo
20. Las mujeres parecen estar por naturaleza menos capacitadas que los hombres para el razonamiento lógico y científico.
- a. Completamente de acuerdo
 - b. Bastante de acuerdo
 - c. Levemente de acuerdo
 - d. Levemente en desacuerdo
 - e. Bastante en desacuerdo
 - f. Completamente en desacuerdo
21. En general, los hijos de madres que trabajan fuera de la casa son tan normales como los hijos de las madres que se quedan en la casa.
- a. Completamente de acuerdo
 - b. Bastante de acuerdo
 - c. Levemente de acuerdo
 - d. Levemente en desacuerdo
 - e. Bastante en desacuerdo
 - f. Completamente en desacuerdo
22. Las reparaciones en el hogar son responsabilidad del esposo.
- a. Completamente de acuerdo
 - b. Bastante de acuerdo
 - c. Levemente de acuerdo
 - d. Levemente en desacuerdo
 - e. Bastante en desacuerdo
 - f. Completamente en desacuerdo
23. En situaciones donde tanto un hombre como una mujer llenan idénticos requisitos para un empleo o ascenso, el puesto debe ser para el hombre.
- a. Completamente de acuerdo
 - b. Bastante de acuerdo
 - c. Levemente de acuerdo
 - d. Levemente en desacuerdo
 - e. Bastante en desacuerdo
 - f. Completamente en desacuerdo

24. La mujeres son mas indecisas e inestables en sus decisiones que los hombres.
- a. Completamente de acuerdo
 - b. Bastante de acuerdo
 - c. Levemente de acuerdo
 - d. Levemente en desacuerdo
 - e. Bastante en desacuerdo
 - f. Completamente en desacuerdo
25. Las mujeres son tan racionales como los hombres.
- a. Completamente de acuerdo
 - b. Bastante de acuerdo
 - c. Levemente de acuerdo
 - d. Levemente en desacuerdo
 - e. Bastante en desacuerdo
 - f. Completamente en desacuerdo
26. El lugar de la mujer es en la casa.
- a. Completamente de acuerdo
 - b. Bastante de acuerdo
 - c. Levemente de acuerdo
 - d. Levemente en desacuerdo
 - e. Bastante en desacuerdo
 - f. Completamente en desacuerdo
27. En caso de emergencia en el hogar, la madre debe ser la primera en dejar el trabajo para ir atenderla.
- a. Completamente de acuerdo
 - b. Bastante de acuerdo
 - c. Levemente de acuerdo
 - d. Levemente en desacuerdo
 - e. Bastante en desacuerdo
 - f. Completamente en desacuerdo
28. Los hombres tienen mas liderazgo que las mujeres.
- a. Completamente de acuerdo
 - b. Bastante de acuerdo
 - c. Levemente de acuerdo
 - d. Levemente en desacuerdo
 - e. Bastante en desacuerdo
 - f. Completamente en desacuerdo

29. Las madres que trabajan no le dedican todo el tiempo que debieran a aquello que es su principal responsabilidad, es decir, su familia.
- a. Completamente de acuerdo
 - b. Bastante de acuerdo
 - c. Levemente de acuerdo
 - d. Levemente en desacuerdo
 - e. Bastante en desacuerdo
 - f. Completamente en desacuerdo
30. Tener relaciones sexuales antes del matrimonio es tan correcto o incorrecto para los hombres como para las mujeres.
- a. Completamente de acuerdo
 - b. Bastante de acuerdo
 - c. Levemente de acuerdo
 - d. Levemente en desacuerdo
 - e. Bastante en desacuerdo
 - f. Completamente en desacuerdo
31. Las mujeres pueden controlar sus emociones tan bien como los hombres.
- a. Completamente de acuerdo
 - b. Bastante de acuerdo
 - c. Levemente de acuerdo
 - d. Levemente en desacuerdo
 - e. Bastante en desacuerdo
 - f. Completamente en desacuerdo
32. Es bueno que haya cierta cantidad de igualdad entre el hombre y la mujer pero al fin y al cabo debe ser el hombre el que decida.
- a. Completamente de acuerdo
 - b. Bastante de acuerdo
 - c. Levemente de acuerdo
 - d. Levemente en desacuerdo
 - e. Bastante en desacuerdo
 - f. Completamente en desacuerdo
33. No debiera exigirse que la mujer cambie de apellido al casarse.
- a. Completamente de acuerdo
 - b. Bastante de acuerdo
 - c. Levemente de acuerdo
 - d. Levemente en desacuerdo
 - e. Bastante en desacuerdo

f. Completamente en desacuerdo

34. Las mujeres deben poder invitar a salir a los hombres.

a. Completamente de acuerdo

b. Bastante de acuerdo

c. Levemente de acuerdo

d. Levemente en desacuerdo

e. Bastante en desacuerdo

f. Completamente en desacuerdo

APPENDIX F

RELATIONSHIP ASSESSMENT SCALE

Answer each question by choosing the one that identifies how you feel about your relationship.

1) How well does your partner meet your needs?

1	2	3	4	5
Poorly		Average		Extremely well

2) In general how satisfied are you with your relationship?

1	2	3	4	5
Unsatisfied		Average		Extremely satisfied

3) How good is your relationship compared to most?

1	2	3	4	5
Poor		Average		Excellent

4) How often do you wish you hadn't gotten into this relationship?

1	2	3	4	5
Never		Average		Very often

5) To what extent has your relationship met your original expectations?

1	2	3	4	5
Hardly at all		Average		Completely

6) How much do you love your partner?

1	2	3	4	5
Not much		Average		Very much

7) How many problems are there in your relationship?

1	2	3	4	5
Very few		Average		Very many

ESCALA DE EVALUACION DE MATRIMONIO

Maque la letra que mejor corresponde a su contestacion:

1. Que tan bien comple su esposo a su necesidades?
A B C D E
Pobremente Medianamente Bien en extremo
2. En general, que tan satisfecho esta usted con su matrimonio?
A B C D E
Disatisfecha Medianamente Satisfecho en extremo
3. Que tan bueno es su matrimonio comparado con otros matrimonios?
A B C D E
Malo Mediano Excelente
4. Que tan seguido se arrepiente usted de haberse casado?
A B C D E
Nunca Medianamente Muy seguido
5. Hasta que grado ha satisfecho su matrimonio sus esperanzas acerca de la vida de casados?
A B C D E
Casi nada Medianamente Completamente
6. Que tanto ama a su esposo?
A B C D E
No mucho Medianamente Mucho
7. Cuantos problemas hay en su matrimonio?
A B C D E
Muy pocos Medianamente Muchos

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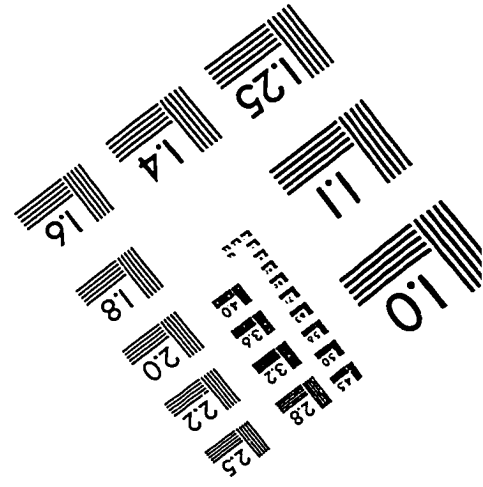
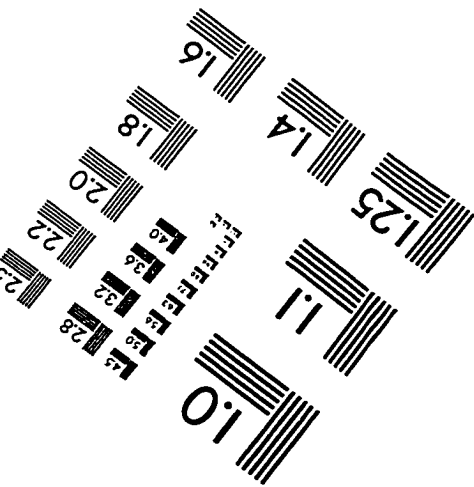
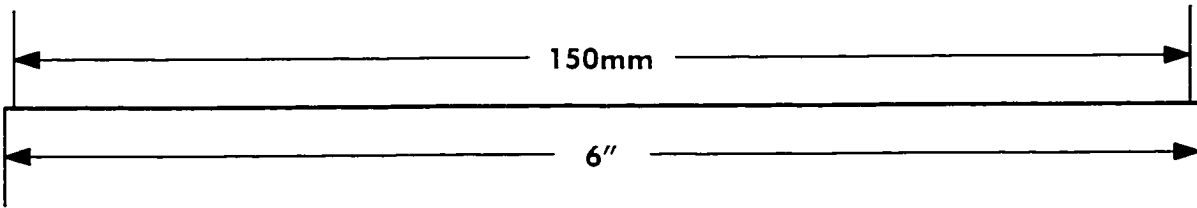
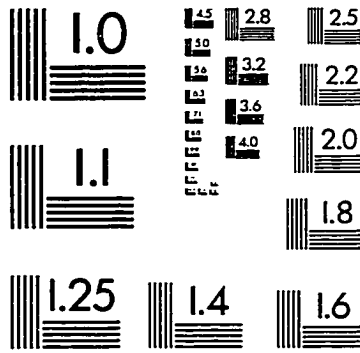
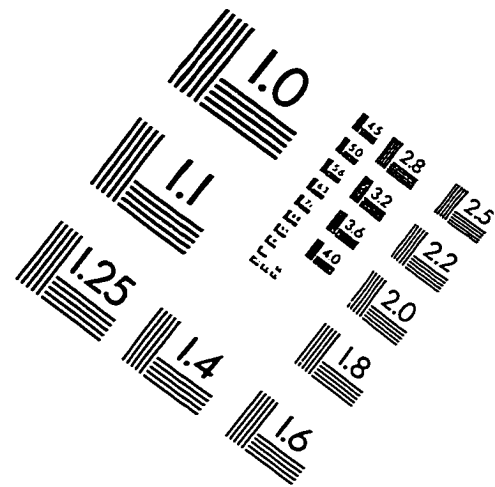
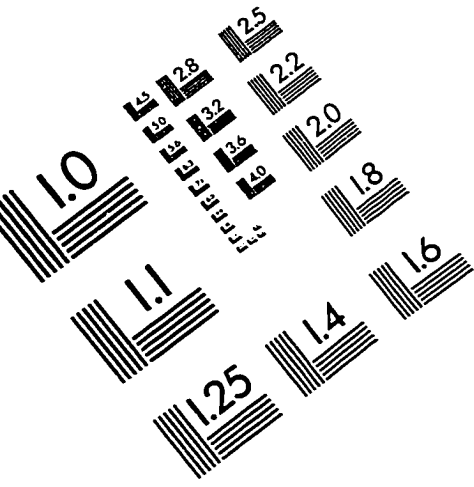
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IMAGE EVALUATION TEST TARGET (QA-3)



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