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Brief Report: “I Can’t Talk About It:” Sexuality and Self-Silencing as Interactive Predictors of Depressive Symptoms in Adolescent Dating Couples

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Abstract

This longitudinal study examined sexual intercourse within adolescent romantic relationships as a couple-level moderator of the association between adolescent individual characteristics and depressive symptoms. Two hundred nine middle- and older-adolescent dating couples (aged 14-17 and 17-21, respectively) reported on their own self-silencing, depressive symptoms, and sexual behaviors. At Time 1, frequency of sexual intercourse significantly moderated the relationship between self-silencing and depressive symptoms, such that adolescents higher in self-silencing engaging in more frequent sex were at risk for clinically significant levels of depression. Adolescents who were low in self-silencing were not at increased risk for depression, regardless of frequency of sex. Self-silencing also significantly predicted increases in depressive symptoms from Time 1 to Time 2. Implications include the possibility that frequent sex in highly self-silencing adolescents exacerbates psychological depletion believed to link self-silencing to depressive symptoms, and that this depletion compounds over time.

The ability to discern the factors that indicate normative, healthy sexuality from that which is associated with psychological turmoil, including depression, is a key task of adolescent researchers (Florsheim, 2003; Welsh, Grello, & Harper, 2003). Past research indicates that sexual involvement at a young age and casual sex are linked to depressive symptoms (e.g., Grello et al., 2003; Joyner & Udry, 2000; O’Beirne & Allen, 1996). Yet, little else is known about the specific nuances of sexual involvement in the context of committed adolescent romantic relationships, or how individual and couple characteristics interact to predict depressive symptoms (Furman & Hand, 2006). Attachment theory (Bowlby, 1969/1980) provides a framework for understanding sexuality in adolescent romantic relationships by suggesting that attempts to negotiate these relationships are likely to be colored by past experiences in close relationships (Bowlby, 1969/1980; Furman, Simon, Shaffer, & Bouchey, 2002), that romantic partners may employ working models of attachment to respond with varying levels of anxiety and/or defensive avoidance in regards to intimacy (Bartholomew & Horowitz, 1991; Brennan, Clark, & Shaver, 1994; Shaver & Mikulincer, 2002), and that the attachment and sexual systems are separate, yet related (Bowlby, 1969/1980). Further, emerging research suggests that attachment insecurity has implications for sexual activity (Birnbaum et al., 2006; Butzer & Campbell, 2008; Little, McNulty, & Russell, 2010).

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Self-silencing is linked to the fear of losing significant relationships and seems to globally impact adolescents' behaviors in romantic relationships (Jack & Dill, 1992; Smith, Welsh, & Fite, 2009). Specifically, self-silencing is a schema for making and maintaining intimacy with a specific partner via avoiding or suppressing self-expression (Jack & Dill, 1992), and is associated with increased depressive symptomology in adolescents (Jack & Dill, 1992; Harper & Welsh, 2007). Further, self-silencing may be a psychologically depleting strategy employed by particularly rejection-sensitive adolescents in an attempt to maintain relationships, which leads them to feel depressed (Harper, Dickson, & Welsh, 2007; Downey, Freitas, Michaelis, & Khouri, 1998; Margolese, Markiewicz, & Doyle, 2005; Sund & Wichstrom, 2002).

This model of relationship maintenance likely influences sexual behavior. For example, some adolescents who are insecure in relationships report engaging in unwanted sex to avoid abandonment (Rodgers, 1996; Tracy et al., 2003) and highly self-silencing adolescents communicate less openly about sex (Widman et al., 2006). The interplay between sexual behavior and self-silencing may exacerbate the depletion of psychological resources associated with depression. However, no known research has examined this question. Building upon Harper and colleagues' (2007) findings, we expect that frequent sexual intercourse will moderate the effects of self-silencing, such that adolescents who are high in self-silencing who also engage in more frequent sexual intercourse will be especially likely to experience depressive symptoms.

Method

Sample

The data for this investigation came from the Study of Tennessee Adolescent Romantic Relationships (STARR). The final sample included a total of 209 adolescent couples: 102 middle-adolescent couples (14–17) and 107 late adolescent couples (17–21). Couples were mixed sex and recruited from a previous study on adolescent dating behaviors of over 2,200 students attending 17 high schools in eastern Tennessee. Eighty-six percent of individuals from the high school study indicated interest in participating in future research, and those who met the age criteria (target adolescent aged 15 or 16 and dating partner between 14 and 17, or target adolescent aged 18 or 19 and dating partner between 17 and 21) and who reported dating their current partner for at least 4 weeks were contacted regarding their willingness to participate. Among those who did not participate: 27% ($n = 603$) were not currently dating, 26% ($n = 595$) were either too busy or not interested, 17% ($n = 375$) were not able to be reached, 7% ($n = 169$) were dating but did not meet the length of relationship criteria, 6% ($n = 142$) were dating but did not meet the age criteria, and 3% ($n = 73$) had parents who refused to allow participation.

The median age of participants was 17 years. The majority of the sample identified as Caucasian (90.2%), with the remainder of the sample identified as African American (6.5%), Asian (1.0%), Hispanic (0.8%), Native American (0.5%), and Other (0.8%). Approximately half of the sample identified their neighborhoods as suburban (47.5%), followed by rural (31.1%) and urban (21.5%). The highest level of education completed by either parent was used as a proxy measure for socioeconomic status. Slightly more than half (55%) of the participants reported that neither parent had a college degree, while almost half (45%) of the sample reported having a parent with a college degree or higher. The median length of time couples had been dating was 31.5 weeks (about 8 months) with a range of 4 weeks to 260 weeks (about 5 years).

Procedure

The sample was recruited as part of a longitudinal study of adolescent romantic relationships. The data reported here is from Time 1 and Time 2. The University Institutional Review Board approved all procedures. At Time 1, adolescent couples came to our facility at their convenience for one three-hour session, and were each paid \$30. Approximately one year after Time 1 participation, adolescents were re-contacted via phone, mail, and email, and asked to participate in a second wave of surveys (Time 2). Written parental consent was obtained for all adolescents still under age 18, and all participating adolescents gave written consent or assent, completed self-report measures via mail or email, and were paid \$15. Of the original 209 couples who participated at Time 1, 197 couples (94%) were represented at Time 2 by one or both members. About half (46.7%; $n = 92$) of the 197 couples who participated at Time 2 reported still dating their partner from Time 1.

Measures

Demographic Questionnaire—Adolescents completed a demographic information questionnaire, including their age, gender, number of weeks dating their partner, and parents' highest level of education (1 = *some high school*, 2 = *high school graduate*, 3 = *technical school*, 4 = *some college*, 5 = *college graduate*, 6 = *graduate school*).

The Silencing the Self Subscale (STSS; Jack & Dill, 1992)—The nine-item Silencing the Self subscale from the Silencing the Self Scale was used to assess the extent to which adolescents inhibit self expression in order to avoid conflict or possible dissolution of their current dating relationship (e.g., “I don’t speak my feelings in an intimate relationship when I know they will cause disagreement”). Culp (1998) suggests that the subscale best measures self-silencing behaviors, rather than the full scale. Respondents rate how strongly they agree with each statement on a five point scale from 1 *strongly disagree* to 5 *strongly agree*. Scores on this scale ranged from 0 to 45, with higher scores indicating stronger beliefs and behaviors of self-silencing. The internal consistency was acceptable for males ($\alpha = .77$) and females ($\alpha = .77$).

The Rejection Sensitivity Questionnaire (RSQ; Downey & Feldman, 1996)—The RSQ includes 18 situations that are designed to assess rejection anxiety, (e.g., “How concerned or anxious would you be over whether or not your boyfriend would want to see you?”) and rejection expectations, (e.g., “I would expect that he would want to see me.”). For each situation, respondents rate on a six-point scale their level of anxiety about the outcome of each situation (1 = *unconcerned*; 6 = *very concerned*) and the likelihood that the other person(s) would respond in a compliant manner (1 = *very unlikely*; 6 = *very likely*). Scores were calculated using the sum of the products of the anxiety and the reverse-coded expectancy scores. There was high internal consistency for males ($\alpha = .83$) and females ($\alpha = .89$).

Sexual Behaviors Questionnaire (Welsh et al., 2005)—Couples reported on a single item asking their frequency of intercourse in the past month (30 days). They selected on a scale where 0 = *never*, 1 = *1-3 times*, 2 = *4-6 times*, 3 = *7-15 times*, 4 = *16-50 times*, and 5 = *51+*. To aid in the interpretation of results, responses were recoded such that 0 = *never*, 2 = *1-3 times*, 5 = *4-6 times*, 11 = *7-15 times*, 33 = *16-50 times*, and 51 = *51+* (within couples' agreement $r = .51$, $p < .001$). Because both partners reported on the same behavior and because individual reports of sexual behavior have been shown to be less reliable (e.g., Jacobson & Moore, 1981), responses were then averaged to create a couple-level item ($M = 5.51$, $SD = 9.38$).

Centers for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977)

—At both time points, participants responded to 20 items describing symptoms experienced during the past week on a four point scale (0 = *less than 1 day*, 1 = *1–2 days*, 2 = *3–4 days*, 3 = *5 or more days*). Scores were summed and ranged from 0 to 60, where scores ranging from 0 to 15 reflect depression levels found in the general population, scores ranging from 16 to 38 delineate “at risk” profiles, and scores 39 and above resemble those of depressed patients in a clinical population (Radloff, 1977). There was high internal consistency for males ($\alpha = .87$) and females ($\alpha = .87$) and scores ranged from 0 to 59 for males, and from 0 to 45 for females.

Relationship Satisfaction Subscale (Levesque, 1993)—Couples reported on the five-item relationship satisfaction subscale from Levesque’s Relationship Experiences Questionnaire (e.g., “Compared to other people’s relationships, ours is pretty good”). Participants responded on a six-point scale ranging from 1 = *strongly disagree* to 6 = *strongly agree*. The items were summed, with higher scores indicating greater relationship satisfaction. The internal consistency of this scale was adequate for males ($\alpha = .70$) and females ($\alpha = .62$).

Results

Descriptive and Preliminary Analyses

Means and standard deviations for study variables (separated by males and females) are presented in Table 1. Self-silencing was significantly greater in males ($t(206) = 6.88, p < .001$), but this was the only difference between males and females. Participants who reported fewer depressive symptoms ($t(413) = 2.63, p < .01$) at Time 1, females ($F(1,416) = 15.28, p < .001$), and individuals with more educated parents ($\chi^2(1, N = 418) = 5.43, p \leq .05$) were more likely to participate in the Time 2 follow-up. Age and minority status were unrelated to Time 2 participation.

Analytic Strategy

Two sets of analyses were conducted using hierarchical linear modeling techniques (HLM) predicting depressive symptoms at Time 1 and at Time 2 from self-silencing, and frequency of sexual intercourse. Gender, age, parents’ highest level of education, rejection sensitivity, relationship satisfaction, and relationship duration prior to Time 1 were controlled in all models, to address potential confounds. Analysis of couple data where the outcome of interest is measured at the individual level is complicated by the non-independence of observations. HLM was specifically designed to decompose variance into common source and situational variance (Bryk & Raudenbusch, 1992). In these models, HLM parses variance into a couple component (differences between couples in depressive symptoms predicted from relationship duration and frequency of sex) and an individual component (differences within couples in depressive symptoms predicted from gender, age, parent education, relationship satisfaction, self-silencing, and rejection sensitivity). HLM analyses provide two types of information: (a) an estimate of the component of variance in the outcome measure (depressive symptoms) that can be attributed to differences between couples and to differences within couples across partners, and (b) information about the extent to which each variance component can be predicted by its respective predictors. Due to some heteroscedasticity of variance among predictor variables, all estimates reported here are using robust standard errors.

Predicting Time 1 Depressive Symptoms

Baseline HLM analyses (bottom of Table 2) revealed that adolescents with greater depressive symptoms tended to date one another, with 25% of the variance in depressive

symptoms attributable to differences between couples ($\chi^2 (2, N = 207) = 346.1, p \leq .000$), whereas 75% of the variance was attributable to differences within couples plus error. Between couples (Table 2, top), differences in relationship duration and sexual intercourse accounted for 40.5% of the 25.2% of variance attributable to between-couple differences. Within couples, adolescents higher in self-silencing and rejection sensitivity, females, and those lower in relationship satisfaction reported more depressive symptoms ($p < .01$). Further, younger adolescents reported more depressive symptoms than their older peers ($p < .05$). This model accounted for 12.2% of the 75% of variance in depression attributable to within-couple differences plus error. There were no significant interactions between self-silencing or rejection sensitivity and participant demographics.

Finally, we tested the hypothesis that frequency of sexual intercourse moderated the relation between self-silencing and concurrent depressive symptoms. Due to the previously established role of self-silencing as a mechanism explaining the relationship between rejection sensitivity and depressive symptoms (Harper, Dickson, & Welsh, 2007), the interaction between rejection sensitivity and frequency of sex was included to conduct a more conservative analysis. We found support for the main interaction hypothesis (see Table 2 - Interaction Between X Within). In couples engaging in sex more frequently (1 SD above the mean), self-silencing was significantly associated with greater depressive symptoms ($B = .40, SE = .11, t(402) = 3.74, p < .001$). However, in couples engaging in less frequent sex (1 SD below the mean), self-silencing was unrelated to depressive symptoms (see Figure 1). Percent variance explained is not computed when between-level interactions are entered in the model ($\chi^2 (2, N = 205) = 291.30, p < .001$).

Predicting Time 2 Depressive Symptoms

Longitudinal effects were calculated using a model similar to the above, predicting Time 2 depressive symptoms and controlling for Time 1 depressive symptoms. At baseline, 13% of Time 2 depressive symptomology was attributable to differences between couples, with the remaining 87% of variance attributable to within couple variance plus error. Depressive symptoms were highly stable over time ($B = .47, t(341) = 5.29, p = .000$). At the couple level, neither time dating nor frequency of sex at Time 1 predicted Time 2 depressive symptoms. At the individual level, only Time 1 self-silencing significantly predicted Time 2 depressive symptoms ($B = .18, t(341) = 2.24, p = .01$), when entered simultaneously with gender, age, parent education, relationship satisfaction, rejection sensitivity, Time 1 depressive symptoms, and the interaction terms. The sex X self-silencing was interaction was not significant.

Discussion

The goal of this study was to better understand the nuances of adolescent romantic sexuality that may be linked to risk and protective factors for adolescent depression. In the current study, only adolescents who reported *both* high levels of self-silencing and frequent sexual intercourse were at higher risk for clinically significant levels of depression. Adolescents engaging in frequent sex who were low in self-silencing were no different in terms of their depressive symptoms from adolescents engaging in sex relatively infrequently, regardless of their self-silencing status. These effects remained even after accounting for demographic and relationship factors. One interpretation of these findings is that engaging in more frequent sex may exacerbate the psychological depletion associated with silencing the self (Harper, Dickson, & Welsh, 2007). Adolescents high in self-silencing and who engage in frequent sex are faced with the task of processing more frequent emotionally-intense events within the relationship, while simultaneously inhibiting verbal expression with the partner. This pattern does not allow for sharing, support, and validation within the relationship that may stave off distress or dysregulation that might develop during such times of heightened

emotionality (Rimé, 2007). Importantly, this is a correlational effect, and a possible alternative explanation is a mediation model, wherein adolescents who are higher in self-silencing may agree to more frequent sex, leading to more depression over time. On the other hand, engaging in more frequent sex may become overwhelming for some adolescents, which could lead them to self-silence and thus feel more depressed. Although these alternative explanations did not emerge in the current sample, as there was no significant association between self-silencing and frequency of sex, they remain to be explored by future research.

Longitudinally, the interaction effect disappeared, and increases in depressive symptoms were driven by self-silencing alone, suggesting that, although sexual frequency has an effect on adolescents' current adjustment, it may be less important for future depression than other factors (e.g., loss of the relationship, starting a new relationship, felt pressure to engage in sex, or future sexual frequency). A better longitudinal understanding of the importance of these factors for adolescent sexuality and depression would be an interesting avenue for future research.

The findings presented here lay another stone on the path toward discerning characteristics of individuals and relationships associated with healthy versus unhealthy adolescent sexuality. Strengths of this study include the involvement of both members of the couple, modeling of individual- and couple-level data, and longitudinal design. Limitations of the study include self-report data and the possibility that adolescents were embarrassed to report about potentially embarrassing sex-related behaviors. Both concerns are somewhat mitigated by the fact that both partners reported about relationship-level variables, thus reducing common-method variance problems and error due to embarrassment. This sample may be somewhat atypical, in that the adolescents agreed to participate in an intense investigation of their established romantic relationships. We believe this makes the findings regarding depressive symptomology even more striking.

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Figure 1.
Interaction effect of self-silencing and frequency of sex on adolescent depressive symptoms.

Table 1

Means and standard deviations of study variables.

Measure	Females		Males	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Time Dating (weeks)	45.58	46.77	45.58	46.77
Age	16.75	1.47	17.42	1.75
Parent Highest Education	4.00	1.56	3.82	1.49
Relationship Satisfaction	24.53	3.77	24.29	3.98
Time 1 Frequency of Sex	4.88	9.94	6.24	11.76
Time 1 Self-Silencing	21.04	6.37	24.86	6.71
Time 1 Rejection Sensitivity	146.07	63.61	149.63	53.58
Time 1 Depressive Symptoms	14.07	8.95	12.81	9.49
Time 2 Depressive Symptoms	15.23	10.34	13.87	10.26

N_{females} = 209; N_{males} = 209

Table 2

Results of HLM analyses predicting Time 1 depression from concurrent self-silencing, rejection sensitivity, and frequency of sex, controlling for time dating, gender, and age.

Between Dyad			
	B	SE	t
T1 Mean Depressive Symptoms	13.29***	0.43	30.61
T1 Time Dating	-0.01	0.01	-0.43
T1 Frequency of Sex	0.05	0.05	1.03
Within Dyad			
Gender	-1.01**	0.41	-2.49
Age	-0.61*	0.27	-2.22
Parent Education	-0.17	0.27	-0.63
Relationship Satisfaction	-0.29**	0.10	-2.92
T1 Self-Silencing	0.23***	0.07	3.48
T1 Rejection Sensitivity	0.05***	0.01	7.75
Interaction (Between X Within)			
T1 Sex X T1 Self-Silencing	0.02*	0.01	2.10
T1 Sex X T1 Rejection Sensitivity	0.00	0.00	1.24
Variance Components			
	Baseline Model		Model
	Variance	Variance Explained	Variance Explained ^a
Between Dyad	21.53	25.22%	40.46%
Within Dyad	63.84	74.78%	12.20%

N_{between} = 205, N_{within} = 402, N_{interaction} = 402

^a percent of baseline variance explained by between and within couples' effects

* $p < .05$,

** $p < .01$,

*** $p < .001$