“‘I Don’t Express My Feelings to Anyone’”: How Self-Silencing Relates to Gender and Depression in Nepal

Dana C. Jack, Bindu Pokharel, and Usha Subba

The following excerpt comes from a young woman seeking treatment at a government outpatient mental health clinic in Kathmandu, Nepal. She has just been diagnosed with major depressive episode by a Nepali psychiatrist and is describing what she thinks has caused her symptoms:

I feel like I may die any time. They [family] treat me very bad, they scold me all the time. Especially my sister-in-law who does not love me or like me at all. My sister-in-law looks for chances to put me down, and most of the time she criticizes me. She even encourages my mother to scold me. She always poisons the ear of my mother. I don’t express my feelings to anyone, I keep it inside me. (Age 18, unmarried, living in a joint family, Hindu, Chhetri caste1)

In this chapter, drawing on interviews, focus groups, and quantitative findings from three studies in Kathmandu, Nepal, we explore the question, does self-silencing associate with depression in a collectivist culture very different from Western, industrialized countries?

In traditional Nepali society, people’s lives are tightly ruled by gender roles, religion, and necessity. The culture is rich and diverse, with approximately 59 ethnic groups and more than 60 different languages, strong communities, and deep, long-standing traditions. Approximately 80% of Nepal’s people are Hindu. Within this group, laws and social practices reinforce a strong patriarchal system with women’s subordination embedded in the family structure, legal system, workplace, health care system, and religion. Women are expected to accept their inequality in society and in intimate relationships: Pursuing one’s own goals is superseded by a collectivist emphasis on the family welfare and serving the needs of family members. Valued personal traits include “sacrifice for
the common good and maintaining harmonious relationships with close others’’ (Oyserman, Coon, & Kemmelmeier, 2002, p. 5), part of a collectivist orienta-
tion. Thus, self-silencing and self-sacrificing harmonize with cultural prescrip-
tions for being a ‘‘good woman.’’ Men carry the power within the family and the
responsibility to provide financial resources, make major decisions, and keep
family cohesion. Masculinity, especially in Hindu society, means being strong and
not revealing sorrow or weakness to others; it also requires enforcing family
members’ conformance with tradition and family values.

Though Nepal’s model of a ‘‘good woman’’ varies among ethnic groups, among
the Hindu it is most influenced by the Brahmanical cultural ideal of the ‘‘good
woman’’ (Bennett, 1983; Skinner & Holland, 1998).2 The idealized Nepali good
woman marries young and becomes a daughter-in-law and wife who is hard
working, faithful, devoted to her husband, and focused on keeping harmony
among family members. The bride, who moves into the husband’s extended
family’s home, is viewed as an ‘‘outsider’’ who serves his immediate family
members’ needs and demands through clearly prescribed rules and restrictions on
her behavior. Early on, a girl is socialized into accepting and enacting her karma
(duty) as the prime virtue of a Hindu woman. Trained since childhood to put her
family first and ignore her own wishes, she is obedient and helpful to her mother-
in-law and other members of her husband’s family. With the birth of sons, she
acquires the central identity of Hindu women—that of a respected mother, ‘‘a
good woman with a good fate’’ (Skinner & Holland, 1998, p. 92). Finally, she
becomes a mother-in-law (the woman with the highest status within the family)
and oversees the lives of her daughters-in-law. In old age, she is economically and
emotionally dependent on her family.
This ideal of a good woman is lived out with expectations that it will lead to security, a sense of belonging and self-esteem within a harmonious extended family. Romantic love is not necessarily anticipated, particularly within arranged marriages in which women care for husbands and in-laws out of duty and tradition. Those whom a woman serves are expected to fulfill certain responsibilities for her welfare. Traditions and family and community pressures reinforce the ideal of the good woman, while long-standing social practices continue to restrict women’s freedoms even though laws increasing women’s equality have recently been enacted. Sons are considered to have economic, social, or religious value; daughters are often regarded as an economic liability because of the dowry system that still exists among most Hindu Nepalese (Fikree & Pasha, 2006). Within some quarters of Kathmandu, these values are strongly challenged by Westernization. But among hill, mountain, and Terai villages, where there is no electricity or media, and where approximately 90% of the population lives (Bal, Pokharel, Ojha, Pradhan, & Chapagain, 2004), few alternatives to traditionalism are available.

Before considering depression in Nepal, we offer a brief sketch of the broader social context in which it occurs. Nearly 40% of people in Nepal have incomes of less than $1 a day; the average per capita income is U.S. $260, making Nepal the poorest country in South Asia, and the 12th poorest country in the world (World Bank, 2006). Women’s health and social standing are very poor relative to men’s. During 2001, women’s adult literacy rate was 26% compared to a rate of 62% among men (EarthTrends, 2003). Women’s lack of schooling and work opportunities, other than unpaid agricultural, give few alternatives to early marriage and childbearing. In 2001, 56% of rural women were married by 18, 25% before 16, and 71% by age 20 (Chow, Thapa, & Achmad, 2001). Nepal’s low Gender Empowerment Measure of 0.385 (United Nations Development Programme [UNDP], 2001) clearly indicates women’s marginalized status rela-
tive to men in economic, political, and professional spheres. Trafficking of girls and women was estimated in 1995 to affect approximately 5,000 to 7,000 females between the ages of 10 and 20, and carries disastrous consequences for victims’ physical and mental health (Human Rights Watch, 1995).

While the social power and possibilities for men may be better than those for women, poverty affects men’s abilities to adequately support their families, with many men having to work outside Nepal, where they are often abused and cheated in host countries. The Maoist insurgency from 1996 to 2006 resulted in approximately 13,000 deaths and large numbers of internally displaced people (Human Rights Watch, 2007).

Mental health in Nepal is a largely neglected area and faces numerous barriers to improvement, including social stigma, inadequate resources such as personnel and health facilities, and a virtual absence of formal mental health services in isolated rural areas, where approximately 90% of the population lives (Bal et al., 2004). No epidemiological data on Nepal’s rates of mental illness, including depression and suicide, have been published. Most of Nepal’s people depend on traditional ways of understanding and treating mental problems, primarily turning to traditional healers. Long-standing cultural practices and even some laws discriminate against those with mental problems. For example, the husbands of women who are considered “mad” (the local slang for mentally troubled, which includes severe depression) can divorce or marry a second wife (Bal et al., 2004), and families can withhold portions of land from a member considered mad (Pach, 1998). In Nepal, depression manifests most often through physical symptoms including persistent headaches, weakness, and bodily pain, a pattern of symptom expression similar to that found in many Asian societies that stigmatize mental illness (Lauber & Rossler, 2007): Physical complaints serve as the idiom for depression (Kleinman & Good, 1996). There is no Nepalese word for depression equivalent to the Western concept. The closest term is “dukkha,” which means suffering.

Background of the Studies

In 2000–2001, thanks to the Fulbright program in Nepal, the first author was privileged to teach in Tribhuvan University’s graduate program in Women
Studies and to collaborate with Nepali colleagues on studies designed to examine the cultural relevance of self-silencing and its relationship to depression and gender. Prior to using the Silencing the Self Scale (STSS, Jack & Dill, 1992) in Nepal, the conceptual equivalence of STSS items and their meaning were adapted to Nepalese culture and language through the translation monitoring process (Van Ommeren et al., 2001) that includes translation by Nepali colleagues, back-translation, four focus groups with literate and nonliterate women in Kathmandu to ensure relevance and clarity of concepts, and psychometric studies.

Two-week test-retest reliability of the finalized adapted STSS was established with a group of 95 master’s students at Tribhuvan University. Scale alpha for the 39 women was .79; for the 56 men it was .69. Convergent validity was established by predicted correlation with major depression as measured by the Composite International Diagnostic Interview (CIDI), Section E 2.1 (World Health Organization, 1997) that assessed point prevalence of depression. Correlations of the STSS and the CIDI were as follows: women: n ¼ 39, .56, p < .001; men: n ¼ 56; .28, p < .05.

Next, working with Nepalese psychiatrists from Tribhuvan University Teaching Hospital and Patan Mental Hospital, we explored the question, how does culture affect depression and self-silencing. Women and men seeking help at the only two government outpatient mental health clinics in Kathmandu, if diagnosed with unipolar major depressive disorder (according to the Diagnostic and Statistical Manual of Mental Disorders, fourth edition [DSM IV]) by Nepali psychiatrists, were asked by the interviewers if they wanted to participate in an in-depth interview exploring what they thought was causing their distress. All the participants were assured that participation was voluntary and that no identifying information would appear in reports, nor would their personal details be revealed to clinic staff.

After informed consent was explained, interviewers asked participants to respond to the following: (1) demographic questions; (2) a semi-structured interview, which had been reviewed by the participating psychiatrists, pilot tested, and revised before use in the study; (3) the CIDI that assessed point prevalence of depression; and (4) a shortened version of the STSS (containing representative items from each of the four subscales: #2 through 9, 15, 16, 19, 25, 29, and 31) (see Jack & Van Ommeren, 2007, for details). We shortened the STSS since all questions on the CIDI depression section had to be included and giving both
instruments in full, verbally to nonliterate participants, would have been too demanding of their time. The interview lasted from one to two hours.5

The consecutive sample consisted of 34 women and 62 men. Women participants in the outpatient clinics study ranged in age from 18 to 68, with a mean age of 37; men’s ages ranged from 15 to 73, with mean of 30. Fifty-seven percent of women were nonliterate compared to 11% of men, and only 3% of women and 16% of men had attended college. The larger number of men than women seeking help at the clinics reflects the Nepalese practice of spending family resources more willingly on male members than female, and men’s freedom and financial ability to seek help themselves without family consent.

Psychiatrists’ diagnoses of major depression corresponded with the point prevalence measure of DSM-IV depression (CIDI, WHO, 1997) for women (97%) and for men (95%). Cronbach alpha for male outpatient participants using the shortened STSS was .696; women’s was .674. Means on the shortened STSS were not significantly different for women (M 1/4 47.68; SD, 8.12) and men (M 1/4 47.26; SD, 8.73), t(94) 1/4 .23, ns. The correlation of total depression symptoms on the CIDI, Section E, and STSS scores among the outpatient participants were as follows: women: n 1/4 34, .23, p < .05; men: n 1/4 62, .48, p < .001.

Because the STSS correlated with the CIDI among the male students in the validation study and depressed male outpatients, we decided to conduct focus groups to explore the meanings each gender attributed to items selected from the STSS. Announcements in undergraduate classes at Tribhuvan University, Kathmandu, Nepal, requested volunteers to fill out three questionnaires and engage in focus group discussion of “things about yourself and your experiences.” Students were advised that their participation in groups would take approximately two hours and were also offered a payment of Rs 100 (approxi-
mately $1.50). One hundred students responded to the invitation: 50 women and 50 men. Coauthors Bindu Pokharel and Usha Subba led 11 focus groups, 5 composed of women only (2 groups of 8 women, 3 groups of 10 women), 5 of men only (2 groups of 8 men, 3 groups of 10 men), and one group with 4 male and 4 female participants between September 2002 and July 2003 (see Jack, Kim, Pokharel, & Subba, 2010).

Participants completed a demographic form, the STSS, and the CIDI, Section E, and then discussed specific items from each of the STSS subscales. In this chapter we report their discussions of items 8, 16, 29, and 31, which had been among those administered to the clinic participants: #2 through 9, 15, 16, 19, 29, and 31.

The women comprise an elite and unusual group compared to most women within Nepalese society. Relative to the larger population (within their age group), the overall enrollment of women in higher education was 3% in 2001, compared to 8% of men (Women in Development Network [WIDN], 2007). Compared to the female outpatient participants, most of whom were nonlithe-rate, these undergraduates were gaining new images of their possibilities through education. Thus, the focus groups offer a brief glimpse of how their relational schemas, measured by the STSS, are affected as traditional female role requirements collide with new personal opportunities. For the young men, education also offers opportunities and yet, in 2002–2003, when the focus groups occurred, men’s prospects were being negatively affected by the social upheaval and turmoil during the Maoist conflict. Thus, men found themselves responsible for economic provision for families at a time when their chances for employment and career were severely limited.

Overall, male participants were older (mean age 25.98) than females (mean age 24.26). Women and men did not significantly differ on the following: marital and
parental status, type of family (50% of women and 40% of men lived in joint families), religion (all women and 90% of men described themselves as Hindu), and income, with most reporting “average” income.

Cronbach alpha among women in the focus groups was _ 1/4 .792; for men it was _ 1/4 .561. Levels of self-silencing did not significantly differ for women and men, nor did women and men score differently on any of the items discussed in the focus groups (#8, 16, 29, and 31). Unlike findings in most depression studies, more men (n 1/4 12) scored as experiencing major depressive episode by the CIDI than women (n 1/4 9). For women only did self-silencing correlate with depression symptoms (.315, p < .05); the correlation among men was .187, ns. Finally, we compared means of the shortened version of the STSS used with outpatients with a similar calculated score for focus group participants and found significantly higher levels of self-silencing among the depressed outpatients relative to focus group participants both overall and by gender.

Listening to Self-Silencing in Nepal: Depression, Life Contexts, and Cultural Patterns

As depressed Nepali women and men describe the factors they think created their distress, women’s narratives powerfully reveal the impact of gender inequality on their lives.8 While both women (70%) and men (50%) most frequently describe problems in their relationships, 40% of women pointed to problematic relationships with their spouse, while 18% of men did. Thirty-five percent of women identified problems in relation to in-laws, while none of the men did. It is not surprising that women, but not men, report problematic in-law relations because the women live with their in-laws while their husbands are treated royally when they visit their wife’s parents.

The outpatient women describe marital relationships of financial dependence, roles that require them to serve men and in-laws, physical and sexual abuse, truncated educational and occupational opportunities, and, for many, early marriages or widowhood that bring severe difficulties. For example, 60% of the women who considered their symptoms as caused by problems in their relationships described being beaten by husbands, while 8.8% said they were being beaten by in-laws. In 79% of women’s interviews, relationship and economic problems overlapped; their narratives reveal that economic dependency made them unable to leave an entrapping relational situation (see Jack & Van Ommeren, 2007, for details). These factors not only contribute to women’s feeling of a precarious existence but also encourage self-silencing as a survival...
strategy to avoid dire emotional, physical, and economic consequences from more powerful men and in-laws.

The high rate of familial violence reported by female outpatient participants is not unusual in Nepal, where more than one-third of women of all age cohorts have experienced violence against them in their homes (Bal et al., 2004; Paudel, 2007). The linkage between violence against women and depression is well established by studies in many cultures; yet, in Nepal, there is a “cultural silence on violence in the family” (Paudel, 2007, p. 217). Being a victim of battering is a known precipitant of depression and other health problems in women (see Astbury, Chapter 2).

Depressed male outpatients listed inadequate income (50%) on a par with relationship problems as causing their symptoms (50%). Problems with work overlapped with income concerns in almost every instance. Men also described health problems as causes of their distress. The details of the men’s family problems will be presented in the examples that follow.

What does self-silencing sound like among these Nepali women and men diagnosed with major depression in the outpatient study? Given their difficult social and material life circumstances, does the self-silencing construct add any explanatory power for understanding precipitants of their depression? We will draw on interviews from depressed outpatients and focus group undergraduates to illustrate similarities and differences on the four subscales of the STSS: Care as Self-Sacrifice, Silencing the Self, Divided Self, and Externalized Self-Perception. (For a full explanation of the subscales, see Chapter 1.) The relational schemas represented by these subscales reinforce each other so that as one aspect is strengthened, it heightens the other three. Subscales are intended to capture the phenomenology of depression and have no specific order of importance (Jack & Dill, 1992). For example, the more a woman perceives herself through others’ eyes (Externalized Self-Perception), the more she may feel a requirement to engage in self-sacrificing behaviors that are part of the female “good woman” role (Care as Self-Sacrifice); silence her own desires, voice, and feelings
(Silencing the Self); and outwardly comply with others’ expectations while inwardly resisting or rebelling (Divided Self). In U.S. studies, the dynamic of silencing the self contributes to a fall in self-esteem and feelings of a loss of self, and associates with depression across a wide range of studies (see Chapter 1). The four subscales are neither discrete nor mutually exclusive; thus, the following examples will contain aspects of more than one schema.

Care as Self-Sacrifice: Examples from Outpatients Diagnosed as Depressed

This construct reflects the ‘‘good woman’’ morality of selflessness that was central in the narratives of depressed women in the United States (Jack, 1991, 1999). Placing the needs of others before the self as a moral demand and as a required behavior reveals one way social subordination is internalized: A woman considers her needs and wishes as less deserving than those of others for whom she cares. This rule of subservient ‘‘goodness,’’ when continually followed, both reflects and lowers one’s value and negatively affects self-esteem. What occurs in Nepal, when care as self-sacrifice is demanded of women through strong cultural traditions?

In the depressed outpatient women’s accounts, self-sacrifice is a constant in their lives, yet they receive none of the expected returns for this caring behavior. They describe that putting others first occurs within negative relationships that are characterized as disconnected, debasing, emotionally abusive, and/or violent.

Explaining the troubles and hostility in her family, Sarmila, age 42, from a small village outside Kathmandu, expresses resentment that her self-sacrifice has not brought expected benefits within the family. She describes herself as the daughter-in-law in a family of six with average income, a Hindu of the Chhetri caste, and
nonliterate. Her STSS (short form) score was 42, less than one standard deviation below the outpatient women’s mean of 47.68.

I was the one who found wives for my brothers-in-law. Because the responsibility was on me for all household things, I did not attend to my own happiness at all. Once the in-laws were married, all our family was scattered. I had to take care of all the festivals, and now I continue to be responsible for taking care of my relatives because my sisters-in-law do not do anything. I feel that I never get anything back when I give to others. I cannot talk to my husband because he has heart problems. Women have to stay and sacrifice for men. My in-laws dominate my children, saying bad things about them and to them, and my in-laws hate me. My husband has a second wife.

After 29 years within her husband’s family, Sarmila finds herself isolated among in-laws who do not value her long-term contribution to their welfare. Though she has followed the traditional life path and behaviors of a good Nepali woman, Sarmila has not experienced any positive returns. Instead, she feels disconnected and isolated by the family’s hostility, even that her in-laws hate her.

Married at 13 and completely dependent on this family, Sarmila has hidden her feelings behind outward compliance and self-sacrificing, “good woman” behaviors. But the litany of injustices in her narrative shows that Sarmila is clearly angry and resentful. She describes her current symptoms as precipitated by her family’s increasing animosity toward her children’s future. It appears as if Sarmila could endure her own maltreatment and disconnection, but not when it extends to her son or daughter. The family (including her husband) dismisses her daughter’s future marriage as unimportant, as unworthy of the family’s resources or obligations: “My in-laws dominate my children and say that my daughter will do a ‘flying marriage’ [go off with any man without a formal marriage ceremony] so they do not need to arrange one.” Also, her sister-in-law is now turning against her son, saying that he will inherit none of the family
property. Her family’s insulting refusals to help arrange a suitable marriage for her daughter and their hostility to her son’s inheritance signal that her children’s positive future is severely jeopardized. Her family is not fulfilling their duty to care for its members, leaving her self-sacrifice unrewarded, her children excluded, and her security in old age threatened.

Sarmila has little power within the family to influence these events that are central to her life. Being reflected as marginal and valueless to her family threatens her interdependent sense of self, a self that is part of and depends on the extended family. It also threatens her self-esteem which is based on the regard of others, particularly within the collective “we” of the family. Saying that she “speaks to no one about my troubles,” Sarmila’s distress becomes so overwhelming that she takes the unusual step of seeking outside help at the clinic. Doing so reflects the depth of her alienation from family as well as her despair.

Men’s outpatient narratives provide examples of the care as self-sacrifice construct that sound very different from women’s. To understand, we must look through the frame of the “good man” as pictured in Nepal. This idealized image contains specific standards by which a man often measures his success or failure: providing for the family, achieving status in the community, and exercising family leadership. Traditional masculinity, especially in Hindu society, requires hiding weakness and vulnerability. It also requires competition and assertion in wider society, depending on one’s caste. Describing what caused their symptoms, men in the outpatient study primarily detail tension around the roles they are expected to perform, a lack of respect from their family, or being distressed by family members’ nonconforming behavior that threatens family reputation.

In addition to different norms of goodness that direct their self-evaluation and feelings of despair, men and women have different power and prerogatives in Nepali society. Men are less subject to the will of others and have greater personal freedom than women, but they bear the major responsibility for the family’s survival. For men in Nepal, “responsibility for the family’s survival” is a more accurate name than “care as self-sacrifice” for the relational schema that directs their self-sacrificing behavior. Men often must sacrifice their own goals and desires to provide for the family. Yet, in Nepal as in many countries, providing economically for the family affirms and supports men’s dominance. Conversely, the inability to provide adequately for the family can threaten a man’s sense of masculine identity and his feelings of worth. The following example reveals the interconnections among these aspects of male identity, self-sacrifice, and self-silencing.

Krishna, age 28, Hindu, of the Chhetri caste, is married with two daughters and lives in a joint family of 11 in a small village in far eastern Nepal. He is the second
son. His STSS (short form) score is 61, roughly one and a half standard deviations above the male mean (47.26).

We men have goals in our life. But since I left school I could not reach the level of my friends. My older brother used to stay away from the village because he was a government jobholder. All of the family workload is borne by me. Because of this I was down. I felt low. I started worrying about it. Finally it got worse. Yesterday...I had a severe headache. I had difficulty in breathing. Friends took me to the hospital and the doctors told me to go to mental hospital.

Krishna also describes his self-silencing and psychological despair.

Recently I am not confident. I think about too much. I hide things. I can’t think of any new plan. It’s not seen that I am suffering from sickness while I am with friends. It worries me very much. When angry at times I am violent; I beat people then later I regret it. I feel I will die. It’s really hard to show people how bad my suffering is. I want to talk but I don’t. It is really hard to control my brain.

Summing up the primary reason for his symptoms, he says, “I am not to be able to be as good as others.”

Krishna begins with the central issue that repeats through his interview: He cannot reach his goals and, comparing himself to others, he feels inferior. Because he left school at 16 to marry for love rather than wait for his family to arrange a marriage, his brother and friends have surpassed him in status and options. They have jobs and income and live away from the village, visible aspects of male success. He is sacrificing his own goals to bear “all of the family workload,” which makes him feel trapped. Anxiety and hopelessness accompany his inability to think of a new plan to improve his life. Krishna feels his responsibility to the family intensely, yet also yearns to chart his own path as his brother and friends have done. Caught between these two incompatible aims, he becomes seriously depressed.
Guided by a masculine script, Krishna does not reveal his vulnerability to anyone; instead, he self-silences. He also describes the behaviors of a “divided self” as he presents an outwardly normal self to others while hiding his suffering. His isolation and disconnection only reinforce his humiliation and despair. In accord with cultural norms for men’s emotional expression prevalent in Nepal and many other countries (Moller-Leimkuhler, 2003), he expresses depression through anger and violence. Self-silencing furthers his disconnection, increases his anxiety over his conflicts, lowers confidence, and creates a trap of self-imposed isolation: “I want to talk but I don’t.” The distress that brings Krishna to the clinic is so intense that he feels like he “will die.”

The relational schemas that direct Sarmila’s and Krishna’s behaviors are clearly shaped by cultural pressures regarding gendered behaviors in Nepal. They take opposite form in the two preceding examples. Sarmila experiences despair when fulfilling the expected role of self-sacrifice does not bring emotional closeness, security, and belonging within the family. Her social powerlessness leaves few alternatives for her life. Though Krishna has social power, he carries the male role responsibility to provide for his family. His distress arises from the incompatibility of his desires to pursue his more individualistic, personal goals as they directly conflict with his family responsibilities. His self-sacrifice comes through providing his labor for their survival. His feelings of conflict and unhappiness as he fulfills this cultural requirement lead to anguish, which he hides by self-silencing.

Care as Self-Sacrifice: Examples from Undergraduate Focus Groups

In the undergraduate focus groups, married women’s discussions of care as self-sacrifice were filled with descriptions of putting husbands and their husbands’ families first, while unmarried participants focused on fathers and brothers. Unlike
the depressed female outpatients, most undergraduate participants critiqued the model of selflessness expected of women, yet they are participants as well as observers of the behaviors they describe: “Our culture and society always demands that we should play a certain role of sacrificing ourselves to please men in every sphere of life as mother, wife and daughter who provides love and security to men.” Their critical assessment highlights the rapid changes occurring in Kathmandu as women experience their own personal aspirations. Nevertheless, the relational schema that one should be selfless, that is, pleasing, compliant, and putting others’ needs first, maintains a strong grip on their thoughts and actions.

The following quotes from focus groups participants had wide consensus:

“‘One should act especially to please her own husband because, by nature, men rule over women’s freedom and constrict their desires.’

“‘Women always sacrifice their interest and desires to keep their relationship and tolerate everything to some extent because our society does not allow us to go live alone separate from the family. The family and children are everything in the life of women.’

“‘Women are always tolerating events and demands of their husbands and family members because of their maternal home. The husband’s family always accuses the daughter-in-law’s parents and relatives if she makes any mistake; they will disrespect her parents.’

“‘We give priority to our husband’s happiness to maintain conjugal life. We learn such behavior from mothers and sisters in law who always give husbands first priority. Before marriage, parents teach their daughters to give more care and love to the family where she is going to marry than to the family of origin. It is one of the good traits of the ideal daughter in law that one should follow to keep joint family atmosphere good.’

Undergraduate men also emphasize the importance of families and family harmony in their lives; however, their self-sacrifice is not based on pleasing but on respect for hierarchy in the family. The majority in each focus group agreed that “‘they all try their best to keep their family happy’” and make sacrifices for
the elders in the family, primarily parents. For example, ‘‘I am studying just to please my parents. I wanted to work in a business but because of my family I am doing a degree.’’ ‘‘I married the girl chosen by my parents even though I did not want to get married at the time.’’ ‘‘My plans were to go into the army but because of my parents I am studying economics.’’

These young men also discussed the responsibility they bear for the family: ‘‘Being the eldest son, I am responsible for the happiness of each family member of the home, fulfilling their needs and providing security.’’ ‘‘They [men] are the source of happiness of their family – their life-partner and others.’’ Some men explicitly disagreed with the requirement for self-sacrifice: ‘‘It is necessary to have self-esteem, and act like a man. Society doesn’t demand that we sacrifice our interests and will for the sake of others’ happiness.’’

While women’s examples reveal that they self-sacrifice for men, men’s examples show that they expect their wife’s or future wife’s adjustment to the man’s home and his wishes:

‘‘It is not necessary to act in a special way to please my life partner. She is also a part of the family and should blend into the home atmosphere, take care of herself, and not be demanding of me to treat her differently.’’

‘‘When my wife wants something, it is difficult. I try to manage the situation by being neutral, trying not to please nor rebuke her.’’ Other men agreed, saying, ‘‘If we please our wives, other members of the [joint] family will be angry with us and say, ‘I am henpecked [joitingre].’’

A married man said he will agree with his wife to please her only after evaluating her wishes in light of acceptability to society and his family norms: ‘‘If she [wife] wants to wear a skirt instead of a traditional sari or kurta surwal, I cannot give permission to her.’’ This statement gained wide agreement in his focus group.

Thus, while both women and men stress the importance of maintaining family harmony, they do so in very different ways—women by sacrificing their ‘‘interests and desires’’ to men who have social power, men by reinforcing the family hierarchy through obedience to elders and expectations of conformance from wives. Among undergraduate men, as in the depressed men’s example, ‘‘care as self-sacrifice’’ does not capture the flavor of the schema that directs their behavior in relationships. Rather, the phrase ‘‘responsibility for the family’’ also more accurately encompasses their descriptions.
Silencing the Self and Divided Self: Examples from Outpatients Diagnosed as Depressed

The Silencing the Self schema directs a person to keep “unacceptable” thoughts out of expression in intimate relationships. Divided Self represents a person’s presentation of an outer self that does not correspond with inner thoughts and experiences. While the person outwardly complies with expected behaviors, inwardly, he or she often feels angry and rebellious (Jack, 1991, 2003). How do these concepts sound in interviews with depressed Nepali women and men and in the focus groups, where the cultural requirement to maintain family harmony would seem to encourage self-silencing and the experience of a divided self?

The following example shows how silencing the self interlocks with the experience of a divided self in depression. Sushma is 35, Hindu, of the Chhetri caste, and lives in Kathmandu. She has never attended school and is nonliterate. Her STSS score is 49, less than one standard deviation above the women’s outpatient mean. An arranged marriage at 15 to a husband who was 30 has severely curtailed her options. She says that she came to the hospital on her own for symptoms of ‘‘sleep disturbance, I am easily irritated, have a heaviness of my head—I feel some movement inside my head, appetite loss, and fearfulness. While walking on the road I become afraid.’’ When asked what she thinks has caused her symptoms, she responds:

When I got out [of the hospital], my husband beat me as I was unable to do house chores, and my husband never loved me. I have three children but he still beats me when he is drunk. My husband is the main cause of my illness. Because of him I am ill. He never cared about me, he does whatever he wants. He doesn’t listen to me. Every night he is drunk and he tries to manipulate my children saying ‘Your mother will leave you one day.’ There are five people in my family and we all live in one rented room. We have to
cook and sleep in the same room. My husband is an electrician, my children study, so the economic condition is very bad.

Sushma illustrates themes common to the depressed participants: arranged marriage at a young age to an older man, economic dependence on her husband, and marital violence with few options for escape. She feels isolated and powerless in a nuclear family without possible help from an extended family or other women within a village. Her feelings accurately reflect these factors and, together with her gender inequality, powerfully affect her agency.

Sushma states, ‘‘I do not share anything with anyone else.’’ She despairs at her children’s response to their father’s negative talk about her: ‘‘It is very painful as I took care of them for all this time and now I see distrust in their eyes. They behave differently, they don’t listen to me.’’ Prior to this, Sushma’s children had been a source of positive connection and intimacy. Now she fears that love and support from her children—which is also women’s economic insurance—is being stolen by her husband. Women who are alone do not fare well in Nepali society. Lacking resources, education, or extended family, her choices are limited.

Telling her story for the first time, Sushma does not blame herself for her situation nor does she feel any personal responsibility for her husband’s behavior: She did not make the choice of whom to marry and has little influence over her husband. She has fulfilled all the demands of her role, including bearing two sons and making the best of a bad marriage. She protests her unlucky fate: ‘‘I feel like I am the unluckiest person because my husband does not love me and now my children are changing.’’ In fact, arranged marriage is an uncertain fate for women in Nepal, with no guarantee of a good man or kind in-laws. Not only can a husband be a drunkard but he can also hoard or squander scarce resources.

Sushma’s interview also reveals her divided self: ‘‘I do not have good relation-
ship with my husband. In front of others I act as if nothing is wrong but really things are very bad.’’ Sushma follows the norm of hiding family troubles when with others. But inwardly, she is angry at her husband who ‘‘never loved me,’’ ‘‘never cared about me,’’ ‘‘does whatever he wants,’’ ‘‘doesn’t listen to me,’’ and ‘‘beats me.’’ Sushma is not passive or submissive in accepting her misfortune. As she sees distrust in her children’s eyes, Sushma’s sense of doom and betrayal increases, leading her to take a major step of resistance to her unlucky fate. She seeks outside help. Though a violent marriage may have forced her to self-silence and appear outwardly compliant, her inner anger and despair propel her into action. Realistically, however, Nepal has few long-term solutions for women who are impoverished and nonliterate and who courageously move out of abusive marriages. Sushma may choose to risk the dangers of the street rather than the ongoing humiliation and pain of her marriage when paired with losing her children’s love.

Men’s self-silencing is not associated with inequality, financial dependency, and/or fear of the partner, recurring themes in Nepali women’s interviews. Rather, it most often pairs with a desire to hide one’s shame and fear, and to maintain dominance through presenting an image of strength. While women outwardly present compliance and subservience as part of a divided self, men outwardly present their power, that is, their invulnerability, while silencing feelings that may appear ‘‘weak.’’

The strongest reason for self-silencing among men is not their vulnerability in relationships but their fear and humiliation due to perceived failures to live up to the demands of the male role. The example from Prakash, age 38, married with two children, no formal schooling but literacy, is emblematic. His (short form) STSS score of 47 is close to the male outpatient mean.

I know I am sick, I am here for treatment. I am scared to become mad. I went to other hospitals and they told me to come here to mental hospital. I feel like I am losing myself, my memory power is going down. I am not able to work and if I don’t work I won’t be able to make my family happy. I have headaches. . . . I feel like I will die very soon or I won’t be able to work ever in my life. I always think about my children. My children ask me for school fees and my wife asks for money to buy household things at that time if I don’t have any money, I get angry. I don’t tell anything to anyone or they might go and tell others and laugh at me. They won’t help me at all, I know that very well so it is a waste to tell them about my problems.

Prakash first sketches the terrain of his inner world, a realm where he feels ‘‘scared,’’ that he is ‘‘losing myself,’’ and where he feels he ‘‘will die.’’ He hides these vulnerable feelings of anxiety and pain, fearing humiliation and ridicule if
they become known. His self-silencing leads to a divided self, with an outer self fashioned to appear strong to hide his inner fear. When his wife asks for money, Prakash quickly hides his shame and inadequacy behind a mask of anger. Prakash also fears the stigma that accompanies “madness” in Nepali society, which may explain why he first went to hospitals that have no mental health clinics. He worries about his children’s futures, wanting to pay for their education as insurance for their success and well-being. Prakash’s self-silencing and deeply divided self lead him to suffer in isolation, cut off from the care and concern that he might receive from his family.

Like Prakash, depressed male outpatients are more self-blaming than are the depressed female participants. Perhaps because men have more freedom and power to make choices and pursue their goals, they are relatively more individualistic than Nepali women and thus feel more responsible for their successes and failures. Because a man’s failure in his provider role affects the family negatively, it also can threaten a man’s interdependent sense of self as well as his masculine identity that rests on his achievements, status, and social comparison. Even though the origins of men’s self-silencing and the aspects of self they hide differ from those of women, their silence nevertheless furthers disconnection and associates with depression.

Silencing the Self and Divided Self: Examples from Undergraduate Focus Groups

In each focus group, women spoke about how men’s dominance affects their self-silencing and leads them to behave outwardly in ways that don’t reflect their inner self. The quotes below illustrate the interlocking nature of self-silencing and divided self:

“Because men are the ones that govern women’s desire and interests, we always keep silent even though the situation is very terrible sometimes.” A number of the female focus group participants said that not addressing their own interests or saying their
feelings makes them feel ukus mukus, ‘‘suffocated inside the heart.’’

‘‘I talked with my husband about stopping studies as I do not want to continue, but my husband became angry about it; from then on I never talked about my studies with him. I am continuing my studies because of my husband’s wishes.’’

‘‘I am adjusting to living in a joint family and not saying what I think because they blame ‘educated’ women for the break-up of the family. When we get higher education, we face the stereotype that our in-laws believe it is difficult to make an educated woman obey; the image is that once women become educated, they become selfish.’’

One woman lucidly summed up the tension between her inner and outer realities: ‘‘Our culture and society always demands that we should play a certain role of sacrificing ourselves to please men in every sphere of life as mother, wife and daughter who provides love and security to men. Sometimes I play a fake role to maintain family happiness and peace though it hurts me very badly.’’ Enacting a pretense of outer compliance exacts an inner cost, dividing her experience of self. She can describe what she is doing and why. This awareness likely derives from education, which gives her the freedom of an unsilenced voice of critique at the university, while, at home, she mutes her voice and complies with expectations about her behavior. Gender is actively (re)produced through purposely self-silencing and following prescribed ‘‘good woman’’ behaviors.

These undergraduates actively negotiate the ideologies defining good Hindu women, including the social practices, meanings, and practical conditions of being a wife, mother, and student. For example, one student said, ‘‘It is very difficult to make my husband go out for an outing to minimize boredom. But slowly and gradually, I have convinced him and have been able to keep my own interests intact, but it took a lot of effort and time. I did this because it is culturally prohibited and impossible to go out alone after marriage.’’ This young woman
subverted existing limitations on women’s freedom but stays within traditional confines, working toward a solution in which she could keep her interests alive but not invite criticism or social disapproval. Her example illuminates how women exercise their agency to create a path, without breaking relationships, between their desires and interests and the social structures that constrain them.

Men’s discussion of self-silencing provides a picture that agrees with women’s emphasis on keeping family harmony, but sharply diverges in terms of how and when one does so. For example, across focus groups, most men said that they must silence their opposing voice toward parents and other senior family members: “We must consent and can’t argue. It is the way of keeping peace and harmony in the family; otherwise it will ruin the family life.” But others qualified the preceding statement, commenting that silencing one’s will is only required in trifling matters: “We need to compromise in order to maintain relationships, and compromise is okay for small things. It should not be against your nature and will; otherwise that relationship can be broken at any time.” Other men thought they did not need to moderate self-expression: “We can express ourselves freely. . .because we are the son, or the male.”

Men agreed that they can only show a certain kind of feeling, and not reveal their vulnerability: “A Nepali saying is ‘never show your sorrows to others.’ It gives more trouble to you than it makes you happy.” They describe suppressing vulnerable feelings rather than expressing them. Some agreed with one man’s comment, “Sometimes I take alcohol to make myself able to reveal thoughts that are not acceptable in front of family members so that they will think I am drunk and not in a normal state and that’s why I talk so freely. It is a kind of strategy to speak out loud to feel free of tension.” In other words, alcohol frees the tongue to speak about feelings that are ordinarily disallowed.

In discussing the STSS item denoting divided self, a number of men thought that
“if we try to suppress feelings, it will burst out in anger which takes away the peace of the home. It is impossible to act to please others. It is better to confront a situation directly and make adjustments.” Further, some groups agreed that “sometimes we hide personal weakness and feelings to be good in front of the others.” Men also used the term ukus mucus in Nepali, saying that while trying to suppress the thoughts and feelings “it starts a pain in my chest.” Many men said that “we can’t reveal our inner feelings easily,” with one participant reporting, “I don’t have the vocabulary to make them easily expressed in a proper way.”

Externalized Self-Perception: Examples from Outpatients Diagnosed as Depressed

This concept reflects an experience of self and self-judgment that are based on cultural standards and the opinions of significant others. In a collectivist culture, where individuals are more attuned from the outset to “see the self through others’ eyes,” what meaning might this concept have in relation to depression?13

The fall in self-esteem, present in Nepali depressed participants’ interviews, appeared to be located in an experience of self that is embedded in relationships and in the regard of others. This experience of self has been labeled by Roland (1991, p. 225) as a “we-self” rather than an “I-self” more characteristic in Western individualist countries. While the loss of self-esteem occurs in depression across cultures, in the U.S., it appears most often to derive from a failure to measure up to one’s own, internalized standards. The more individualistic the sense of self, the more the guilt over a “failure” since the individual is accountable, through whatever choices have been made, for creating something of the self. In Nepal, a person’s choices are strongly determined by others in the family and by “fate.”

Depressed women and men clearly locate the “feeling about what I should be” in their ability to fulfill cultural and family expectations. In Nepal, laj, the term most often translated as shame, arises from violations of expected behaviors. For Hindu women, shame accrues when departing from behaviors of the Brahmical cultural model of the “good woman,” especially regarding violations of sexual restraint and modesty (Bennett, 1983; Galvin, 2006; McHugh, 2001; Skinner & Holland, 1998). These values, reflecting the “eyes” of the culture, are experienced as an “Over-Eye” (Jack, 1991), which keeps the self in line with cultural standards and directs ongoing self-judgment and behavior. For example, the restrictions on women’s physical movement, self-expression, and sexuality are internalized and work as a form of self-inhibition and self-surveillance. For men, shame arises when one has fallen short of expectations attached to the idealized “good man,” such as an inability to provide economically for the family, revealing one’s weaknesses or vulnerability, or incidents of obvious disrespect.
Meena, age 22, who has completed a year of college, was brought to the clinic by her parents. Her STSS (short form) score was 48, less than one standard deviation above the female outpatient mean. She met with the interviewer by herself. In response to why she came for treatment, she said, “When I think of the past I am afraid of the future. For the past one and a half months I like to be alone, and do not want to talk to anyone.” After this, Meena answered only yes or no to questions until the end of the interview, when she described the events she felt were causing her symptoms:

When I was 16, I was in love with a man and had an affair for five years. My boyfriend and I had sex many times. [Interviewer: ‘Why did you have a sexual relationship with him before marriage?’] He used to love me so much and we were about to marry, so in this situation, sex did not seem such a big thing. But a year ago, he left me and married someone else. I asked him why and he said, ‘I don’t need you any more. I got what I wanted from you – I needed a pass-time girl, so I loved you and passed a happy time with you, and now I don’t need you because someone else is in my life and she is my wife.’ I could not eat anything for two days and just kept on crying and crying.... I started staying alone in my room and stopped talking to anyone. Even today my parents do not know the reason behind my illness.

Assuming she would marry her boyfriend, Meena violated Nepalese norms that good Hindu women abstain from sex until marriage (even the interviewer asks why she would do so). Suddenly, this man’s humiliating words undercut her own vision of their past love’s reality and her own value. His abandonment holds more than a loss of love—it threatens her identity and her future. If others, including her parents, learn of her sexual relationship, it will be hard for them to arrange a good marriage because she has been “spoiled.” Hindu women in Nepal who deviate from the life path of the good woman are considered problematic and are punished in a variety of ways (Skinner & Holland, 1998, p. 93).
Reduced to nothing more than a “pass-time girl” by the man who held her future, Meena can no longer view her sexual actions as justified by love and future marriage. She had risked flouting cultural standards to choose her own partner and enact her desire. But this rebellion has come to a tragic end. Through whose eyes, through what values, does she now see and judge herself? Struggling over how to interpret herself or envision her future, she, in fact, grapples with her identity as a good or bad woman in Nepal.

Meena’s example also highlights how women fear punishment for sexual transgressions while men do not: Four of the outpatient men described their relations with prostitutes, while one described his sexual assault of a young adolescent girl. The last question of the interview asks, “How do you feel about the interview, and do you have any other comments or questions for us?” Meena replied, “I feel relief but I feel afraid even now because I don’t know what is going to happen next.” Self-silencing increases Meena’s isolation: Alone in her psycho-logical as well as physical room, she fears her future. It is possible that Meena felt better after the interview with the young Nepali female interviewer who was warm and understanding. We do not know what happened with Meena, as she was from a remote district that required days of travel to Kathmandu. She was prescribed amitriptyline and told to return in two weeks. She never returned.

Depressed men’s narratives were filled with the feeling of “what I should be is not what I am.” Men locate the gap between the “should be” and the reality of their lives by measuring themselves against the societal standards of traditional masculinity. As they describe it, this requires being both the primary wage earner and dominance in marriage and the family. In the following example, we can see how this model operates when traditional roles are violated and the wife is the primary wage earner.
Bal, 28, is Hindu, Chhetri caste, and married with one son. He lives in a joint family of 10 in Kathmandu, and has completed primary school. He is the oldest son, and reports that there is not enough food for his family. Bal describes the symptoms for which he seeks treatment: ‘‘I feel heaviness on my head, sometimes my vision is blurry and I can’t identify the person.’’ He says, ‘‘I cannot work, I cannot share things with anyone, I have to bear whatever people say to me.’’ His STSS score is 45, two points below the male outpatient mean. Asked ‘‘Are there difficulties at home that are causing problems?’’ Bal responds:

I can’t stand my wife. I become irritated whenever I see my wife. I want to fight with my wife. I lose my temper at small things. I am always discussing this with my friends. They tease me and make jokes because my wife works and earns more than I do. She is running the family with her money. I become angry when people say that ‘‘you are living on your wife’s money.’ . . . I don’t know why I get so irritated whenever I see my wife. I feel she is my enemy. I have inferiority complex. I feel like my wife tries to dominate me so I beat her. I am always worried about what my family thinks of me because I cannot work and my wife is earning for us. I sometimes feel trapped and regret why did I get married. That is why I am ill. . . . I don’t share my things with anyone. I wish I could work like other people. When I’m angry I go out, I don’t talk to anyone. I beat my wife and son.

Bal clearly sees and judges himself through others’ eyes as he describes his despair. His friends’ barbed teasing defines his disgrace while their jokes convey a cultural requirement. As the oldest son, his duty is to provide the family income and he has failed. Providing the family’s income is a clear standard by which others—as well as himself—measure his success and failure. The double bind—that he and his family need his wife’s income but her income humiliates him—sustains his feeling of being trapped. To ward off the negative judgment, both from himself and others, Bal turns his wife into the enemy and his humiliation into rage and hostility, beating his wife and son in order to reassert his power and control. In Nepali society as well as in many countries, men learn that anger and aggressive-ness are ways to express psychological pain, particularly against women (Moller- Leimkuhler, 2003). Cut loose from his moorings in masculinity and experiencing a loss of face with others, Bal’s self-esteem plummets into an ‘‘inferiority complex.’’
Externalized Self-Perception: Examples from Undergraduate Focus Groups

Undergraduate women in the focus groups agreed with the statement (#31) from the Externalized Self-Perception subscale that ‘‘my feeling about what I should be is not what I am.’’ Their statements to follow reveal that they see and judge themselves from two clashing perspectives: Traditional role requirements compete with new possibilities of achievement. Married women across a number of groups agreed that ‘‘Our roles as wives, mothers and daughters-in-law are obstacles to our academic advancement.’’ One participant said, ‘‘I’m satisfied with my married life but still when I think about my career and compare with my unmarried friends, I feel that I’ve lagged behind.’’ They also said, ‘‘Household responsibilities come to mind at the time of study.’’ Other representative comments include: ‘‘Women are always deprived of family as well as social support for our career development.’’ ‘‘Being the eldest daughter, I have to hold the responsibility for the family and do not have time to think for myself.’’ These conflicts surrounding the feeling of ‘‘what I should be’’ reveal that new opportunities create possibilities and problems for identity and self-judgment as university women try to fulfill competing standards.

The standards men use to see and judge themselves came up strongly as they discussed the sentence ‘‘my feeling about what I should be is not what I am.’’ Their discussions turned quickly to the social obstacles that kept them from pursuing their sense of what they should be or want to be. These obstacles kept them from regarding themselves and their futures positively. Nepal’s political chaos and the social disruption from the Maoist insurgency have brought new pressures on these men. Their concerns included being financially dependent on their families, worry that their future prospects are slim because of the social disruption caused by the Maoist insurgency, concern that they would never be able to financially provide for their family, and that they were not recognized in society and might never be. They also frequently identified social problems that they feared hindered their future opportunities, such as the poor quality of the educational system, disappointment with the university, inadequate English classes, and a failure to be admitted to the department they wanted, as well as other concerns. Male students identified problems with civic society three times more often than did female students, not surprising since men’s lives take place in the public arena, whereas women’s lives are still mostly confined to the home.
When undergraduate men described their feeling that they are not the person they should be, their blame was not self-directed but placed on the political situation, the poor educational system, a civil society that is in upheaval, and the socioeconomic context that offers few career opportunities. However, some of the focus group members blamed themselves for being incompetent in studies, not finding work, or a lack of aggression and initiative in pursuit of their goals.

Concluding Observations and Further Questions

The exploratory studies of women and men presented in this chapter confirm the relevance of the self-silencing construct for understanding depression in Nepal. The situations that women regard as precipitating their distress involve disruption, violence, or problems in a core relationship. These circumstances are characterized by loss, humiliation, entrapment, social inequality, and a lack of viable options in order to exercise choice and control. These Nepal findings offer a useful cross-cultural comparison corroborating known precipitants of women’s depression identified by other studies in South Asia (Trivedi, Mishra, & Kendurkar, 2007) and elsewhere in the world (Broadhead & Abas, 1998; Broadhead, Abas, Sakutukwa, Chigwanda, & Garura, 2001; Brown, 2002; Brown & Harris, 1978; Cabral & Astbury, 2000; Kessler, 2003). They also call attention to the effects of inequality and violence on women’s lives (see Astbury, Chapter 2) and support the vital importance of social action to address these known factors that affect women’s depression.

Numerous studies in the West identify the absence of a confiding relationship as a vulnerability factor for women’s depression (see, for example, Brown, Harris, & Hepworth, 1995). While in Nepalese society, as in other South Asian countries, the majority of people do not usually discuss personal, physical, or mental
problems outside the family, most people have at least one confidant—usually a family member (Rodrigues, Patel, Jaswal, & de Souza, 2003). Research in India, the country with a culture most similar to Nepal’s Hindu society, also identified a woman’s keeping feelings to herself as a central factor in postpartum depression (Rodrigues et al., 2003). Most of the depressed women in Nepal describe isolated disconnection within their families, without a confidant, in a cultural context where one’s well-being and even survival are rooted in familial relationships.

Self-silencing adds an important dimension to these known precipitants. Depression is an illness of disconnection. Interpersonal events that precipitate depression are characterized by their threat of social disconnection as well as the ongoing, stressful experience of living in intimate relationships that are demeaning, conflictual, threatening, and nonconfiding. The very act of hiding feelings from others affirms to the self that what is being concealed is unacceptable or dangerous. Self-silencing, which is elicited and also reinforced by negative relational events, furthers disconnection from others as well as from one’s self. It heightens the impact of adverse circumstances through increasing a person’s isolation, exacerbating the psychological impact of difficult ongoing situations. Threats of isolation from the family (to survival itself) if one communicates unacceptable feelings creates a difficult bind that can activate the pathways of mutual influence among psychological, biological, and social processes that together precipitate depression.

Most people who live in social adversity do not develop a depressive disorder (Trivedi et al., 2007). While each person in the outpatient study identified
expected gendered behaviors with the goal of insuring safety and/or closeness. However, self-silencing reduces the possibility of a close, confiding relationship within which one can share life’s problems while it also creates an inner dynamic of loss of self, lowered self-esteem, and inner division. Is it possible that self-silencing is one of the processes that mediates the relationship between social adversity and depression?

For example, self-silencing might mediate between social adversity and depression through its effect on the self. With India, Nepal shares a collectivist emphasis on the family with an interdependent sense of self. Even though, as attachment and feminist theorists have emphasized, the self is inherently relational and motivated toward connection, culture affects the experience of self, emotions, and behaviors (Oyserman et al., 2002). More research within collectivist cultures would help our understanding of how the construct of self-silencing may affect vulnerability to depression in ways that may differ from more individualist cultures. In addition, social factors such as caste, arranged marriage, and education may strongly affect self-silencing and depression within these cultures. The Nepal studies lay the groundwork for such further research, including an examination of the role of self-silencing as a mediator between adverse social events and depression.

Analysis of the depressed men’s interviews and focus group discussions revealed that the motivations and goals of their self-silencing differed from those of women. For the depressed men, hiding vulnerability through self-silencing in compliance with demands of “masculinity” associates with depression, while it also protects and reproduces men’s position of dominance. Men’s feeling of “what I should be” clusters around different attributes of self than does women’s. As a group, Nepali men enjoy different levels of material and social power than women and face different demands to fulfill their roles: self-assertion rather than self-sacrifice, dominance rather than submission. As a result, their images of relatedness—how to make and maintain relationships—differ from women’s in the “shoulds” that direct behavior and self-judgment. Their moral beliefs about a “good man,” embedded in their relational schemas, direct their self-silencing and restrict their willingness to reveal difficult feelings. From depressed Nepali men’s interviews, it is clear that their self-silencing holds negative psychological consequences of increasing isolation and diminished self-worth.

In the focus groups, women and men scored similarly on the STSS, yet discussions of specific items within the groups revealed that each gender attributed different meanings to the items, underscoring the need for a foundational study of self-silencing in men. STSS mean scores among Nepali students are sharply higher than scores reported for white undergraduates in the United
SELF-SILENCING, GENDER, AND DEPRESSION IN NEPAL 169

States, possibly because collectivist values of self-restraint and harmonizing in relationships do not conflict with self-silencing. As well, the marked gender inequality and strongly delineated gender roles may heighten self-silencing in Nepal and, thus, endorsement of scale items. In Western cultures, self-silencing conflicts with the individualist emphasis on self-development and self-expression, which may curb agreement with scale items.

Silencing the self theory rests on the assumption that the self is relational, that relationships have profound effects on our biological mechanisms, our minds, and on all aspects of functioning (see Schore, 2003; Siegel, 2001). Depression, too, most often appears to be social/interpersonal in origin and effect. Emotional experience and regulation, as revealed in these interviews from Nepal, are not individual processes, but rather interpersonal ones that unfold within specific social/relational contexts, influencing and influenced by biopsychosocial factors. Accordingly, self-silencing is not considered a “response set” of passivity, a stable personality factor, or a form of inadequate coping with difficult circumstances. Rather, the relational schemas that direct self-silencing in women and men are shaped by the objective realities of their lives as well as by the social mentalities within cultures. These schemas affect the most important aspects of their lives: how to connect within important relationships and how to be a valued “good” woman or man in society.

Gender, in Nepal as elsewhere, profoundly affects how one can be a “self in intimate relationship,” what a person may voice, and what must remain unspoken. Depressed women and men in Nepal describe that maintaining family and important relationships is a core value. Even though the self-silencing relational schemas that direct their behavior differ by gender, for both, hiding tormenting feelings and vital aspects of self in order to sustain important bonds plays a central role in precipitating depression.

Notes
1. The Hindu caste system is complex and important in Nepal. In this research, the “untouchable” castes were very few in number and we did not analyze STSS scores in relation to caste. For an overview of caste, see Pradhan and Shrestha (2005).

2. The Hindu epic, the Ramayana from the 3rd century BC, supplies this ideal through the example of Sita, who undergoes one sacrifice after another for her husband, Lord Rama. The story is known in its broad outlines by almost all Nepali Hindus.

3. Vidya Sharma, MD, of Tribhuvan University Teaching Hospital; Nirakar Shrestha, MD, former director of Patan Mental Hospital, the only government mental hospital in Kathmandu; and Mark Van Ommeren, PhD and Bhogendra Sharma, MD, of the Center for the Victims of Torture (CVICT), were collaborators. Without their expertise and help, the work would not have been possible.

4. The CIDI has been translated into Nepali and utilized in a study among Nepali-speaking Bhutanese refugees (Van Ommeren et al., 1999; Van Ommeren et al., 2001). Questions from this measure were asked verbally by trained Nepalese interviewers. The CIDI assesses DSM-IV depression as a binary variable (present/not present) and point prevalence indicates a diagnosis based on the presence of symptoms within the past two weeks.

5. Interviewers had been trained in qualitative interviewing by Dana Jack and in administering the CIDI, Section E, by Mark Van Ommeren. Interviews and the instruments were administered verbally in a private room in the clinic. Interviews were not tape recorded, since such equipment is unfamiliar to many. Interview notes were written out after interviews and translated into English by the interviewers.

6. Bindu Pokharel, PhD, was on the faculty at Women Studies, and now teaches in the Department of Rural Development. Usha Subba was teaching in the Psychology Department at Tribhuvan University.
7. The tertiary gross enrollment ratio is defined as enrollment at third level, regardless of age, expressed as a percentage of the population in the theoretical school-age group corresponding to this level of education. The women’s share of tertiary enrollment refers to the percentage of students enrolled in tertiary education who are female (United Nations Statistical Division, 2004).

8. Written interviews were typed and imported into Ethnograph software, which allows systematic analysis of themes. Five students were trained to code interviews; the following analysis results from the codings.

9. In all outpatient examples that follow, each participant has been diagnosed as depressed by Nepali psychiatrists and also has scored as depressed on the CIDI. All of the examples that follow come from Hindu outpatient participants, and all names are fictitious.

10. While women in the United States also experience a relational self, the “we-self” regard in Nepal appears to be based much more within family relationships. In the United States, it appears more based on the quality of the intimate marital relationship and/or on the “successful” individual self based on one’s achievements.

11. The English version reads, “In a closer relationship I don’t usually care what we do, as long as the other person is happy,” while the Nepali translation says, “Often I don’t take care of my own happiness if it gives happiness to my loved ones.”

12. The Nepali version of item #8 reads, “When my life-partner’s needs and feelings conflict with my own, I will tell him or her clearly” (reverse-scored, Nepali translation), and item #16 reads, “On the outside I am looking happy but on the inside, I am seething” (Nepali translation).

13. Item #31, one of the items in the Externalized Self-Perception subscale, reads in English: “I never seem to measure up to the standards I set for myself.” While the English sentence clearly locates the standards within the person, even as individually chosen, the Nepali translation is more ambiguous regarding the location of the standards: “My feeling about what I should be is not what I am.” The Nepalese translation appears to be more collectivist in orientation, with “what I should be” located not so specifically within the self as self-chosen standards.

14. Roland (1991) describes the “we-self” as follows: “...the inner representational world of Indians is much more organized around images of ‘we,’ ‘our,’ ‘us’; or around an ‘I’ that is always relational to a ‘you,’ usually in one or another kind of hierarchical relationship. This is in contrast, for instance, with the American highly individualistic sense of ‘I’ and ‘me,’ with its inherent duality between ‘I’ and ‘you,’ the
SELF-SILENCING, GENDER, AND DEPRESSION IN NEPAL 171

‘you’ frequently being implicitly a more or less equal other in egalitarian relationships or even hierarchical ones” (cites omitted, p. 225).

References


