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"Women consider the failure of relationships to be a moral failure," said Carol Gilligan, the year I started doctoral studies at Harvard University. It was 1979, on a brilliant fall day with sun streaming through the tall, leaded glass windows in Longfellow Hall. Gilligan was talking about women's psychology in her class on Moral Development. Her words struck my mind and heart, giving direction to all my future work. Why did these words stand out so strongly? With what intellectual and emotional experiences did they resonate? How do they relate to the Silencing the Self Scale (STSS), first reported in the PWQ article on which I have been invited to reflect (Jack & Dill, 1992)? I am grateful for this opportunity in this anniversary section to blend my personal and professional thoughts about self-silencing, gender, and depression. Please find the original article at pwq.sagepub.com/content/16/1/97.

My passion to understand depression undoubtedly has its origins in childhood. During the late 1950s, my parents divorced and my mother sank into a major depression, blaming herself for the failure of her marriage. She often wept, trying to understand what went wrong and asking herself "What have I done?" As a child, I wanted more than anything to understand why and how she thought that way, and how I could help her. I also felt a strong sense of unfairness over her predicament as the woman who was left behind, who went to work at a low-paying job while my father continued his high-income lifestyle. Living in Texas where male dominance was unquestioned, my mother had no sense of the structures that shaped her and through which she evaluated her worth. Even though I was so young, I knew that she was entrapped in a false view of herself. Although my mother was courageous, caring for three children and working outside the home, she felt emptied of value. What was this about?

The pain of her depression, the unfairness that elevated men's possibilities while curtailing women's, and a desire to understand the complexity of what happened to her led to my lifelong quest to investigate depression. Carol Gilligan's words immediately crystallized my understanding that moral themes, because they reflect social standards and provide a basis for self-judgment, offered a new way to examine depression.

My awareness about how social norms had affected my mother's despair was created when I entered Mount Holyoke College as an undergraduate in 1963. Our class had been told to read The Feminine Mystique by Betty Friedan (1963) before we even stepped on campus. In a stirring speech that fall, Friedan proclaimed that we were "Uncommon Women," a designation that stayed with our class for 4 years. Initially, I understood the message to be that we needed to use our privilege and our achievements to avoid the entrapment of an "ordinary," devalued woman's life and that somehow we could and should integrate the opposing behaviors expected of caregivers and future professionals. I caught a glimpse of the factors affecting my mother's despair: her identity resided in the roles of wife and mother, yet these roles had little social worth. After marriage, she had given up a promising career as an artist; she lost her sense of self with the divorce. I also began to experience how society constructs a basic conflict for women: it demands women's selfless nurturance in relationships yet requires assertion for self-development and achievement. These polarities often coexist in an uneasy tension and are still voiced by the young women in my classes. Feminists continue to face the critical task of transforming traditionally "feminine" characteristics and activities such as nurturance, caregiving, generosity, and sensitivity into ones that are gender-neutral and culturally valued. On an urgent, practical level, we also face the challenge of creating social supports for mothers and children within a society that devalues both.

Prior to beginning my graduate studies, I worked as a welfare caseworker in inner-city Seattle. Poverty, humiliation, and violence filled the lives of women on welfare, along with their attempts to resist such devaluation. I learned firsthand how the experience of self is profoundly rooted in social context and the quality of relationships. At that time I read all of John Bowlby's work, seeking to understand the power of...
attachments, and also R. D. Laing and Thomas Szasz, both strong critics of existing ways of viewing and treating mental illness. Studying for a Master’s in Social Work at the University of Washington deepened my appreciation of how society both shapes and evaluates lives. It marginalizes some of less value, entrapping people in poverty while blaming them for being poor, and it creates obstacles to escape from poverty through catch-22 welfare policies. My work has always been fueled by the feminist goal to place women’s psychology within the context of social inequality with a goal of social change.

As a counselor at Western Washington University and at a local mental health clinic, I frequently worked with women who were diagnosed as depressed. There I first noticed a startling discrepancy between what these women said about their experience and what existing theory told me I should hear. Women talked about their sadness and their sense of responsibility for problems in their relationships. They spoke about their confusion regarding their longing for closeness while being told by their cultural surroundings that they needed to be independent and pursue their own goals. They often seemed paralyzed by conflicting voices and goals. Clinical theory, in the mid-1970s, told me I should interpret depressed women’s focus on relationships as evidence of their “overdependence” and of their infantile, oral strivings. They were described as hanging on to their relationships like “leeches.”

The language of “dependence” connected women’s depression to the prevalent ideology of gender stereotypes: that women are immature, weak, helpless, and needy for relationships. It substituted the healthy human need for relationships with an ideal of autonomy, not noticing that it was the ways culture told women they should engage in relationships that affected them. Once the woman was to blame, there was no longer a need to search for cultural conditions—such as social inequality, poverty, or a partner’s hostility—that served to create psychological distress. In 1970, Broverman and colleagues documented that clinicians evaluated feminine characteristics as signs of psychological immaturity whereas masculine stereotypic traits characterized those of a healthy, mature person (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970). Phyllis Chesler’s (1972) critique of how the field viewed women’s “madness” also fueled my resistance to dominant ways of seeing depressed women. Though Aaron Beck’s (1976) influential work contributed an important perspective on the power of cognition related to depression, it did not address how the mind is conditioned by gender or how social context may shape one’s thoughts, behaviors, and feelings of self-worth. Reading everything I could about women’s depression, I saw nothing representing their experiences that rang true, nothing that captured the themes so frequently spoken by women themselves. Depressed women’s points of view, represented in their own words, were absent in the clinical literature in the late 1970s.

I came to doctoral studies deeply skeptical of the field’s view of women’s depression and aware of how significantly social expectations and economic inequality shape women’s lives and minds. Burning questions propelled my studies: Why do women experience depression at rates twice as high as do men? How do their higher rates reflect the social and relational conditions of their lives? How is it that some women, although they have internalized cultural values about how they should be, learn to oppose these values? What is the line between unhappiness or psychological distress and clinical depression?

At Harvard, I was fortunate to have Carol Gilligan as my advisor who, at that time, was writing In a Different Voice (1982). She saw qualitative research as a vital method to introduce women’s perspectives into a field where theory had been constructed from a male perspective. Gilligan herself was acutely attuned to the moral themes in women’s voices, her listening honed through interviews with women considering abortion. I became familiar with the work of Jean Baker Miller, the Stone Center collective, Nancy Chodorow, and other feminists who were all exploring women’s psychology from a relational perspective with an eye to social context. Miller (1976), for example, analyzed why women were “doing good and feeling bad” within relationships of inequality; Gilligan challenged the field’s assessment of an ethic of care as lower-level moral reasoning, seen as stereotypically feminine and mired in conventionality. These visionary thinkers created exciting possibilities for placing women’s words into new theoretical frameworks.

During the late 1970s and early 1980s, qualitative research was regarded with skepticism within psychology. Gilligan’s support and vital engagement with listening to women’s voices provided the validation I needed to move ahead with a qualitative dissertation. Already familiar with the extreme self-condemnation of my mother and former clients, I chose to interview women diagnosed as clinically depressed and to listen for the moral themes in their narratives. Existing theories of depression told me that condemnation of the self on moral grounds—“I’m no good” “I’m worthless”—was simply a symptom of depression and certainly not worthy of investigation. I disagreed. I think that moral language reflects cultural values and judgments—that culture undergirds our very understanding of who we “should” be and how we “should” relate to others.

### Silencing the Self Theory

Listening to the moral language in depressed women’s voices led to my formulation of Silencing the Self theory. Briefly, I argued that because establishing positive, close connections is a primary motivation throughout life, cognitive/relational schemas about how to make and keep attachments are critical for understanding depression. Depressed women’s relational schemas reflect a set of attachment behaviors (such as self-sacrifice, self-silencing, and pleasing) that have evolved through centuries of women’s subordination to men. Such behaviors were designed to solve the puzzle of how to achieve intimacy within inequality. These cognitive schemas about how to create and maintain safe, intimate relationships
lead women to put others’ needs first and to silence certain feelings, thoughts, and actions. This self-silencing contributes to a fall in self-esteem and feelings of a “loss of self” as a woman experiences, over time, the self-negation required to bring herself into line with schemas directing feminine attributes to a fall in self-esteem and feelings of a “loss of self.” This self-silencing contri-

The attempt to create closeness or safety in relationship requires curbing self-expression and leads to the experience of a divided self. On the inside, anger is continually aroused by forsaking the self, while outwardly, one attempts to appear pleasing. This inner division and harsh self-judgment appeared in depressed women’s inner dialogues (Jack, 1991, 1999b; Jack & Ali, 2010). Although self-silencing is undertaken to create harmony in close relationship, ironically, it brings disconnection where intimacy is sought. Depressed women feared that if they tried to be themselves, they would lose their relationships; yet they described having lost themselves in an attempt to create an intimacy that was never realized. Self-silencing inhibits self-directed action, thus also limiting self-development. Part of the hopelessness and helplessness in their depression stemmed from the sense that moving toward one major life goal—intimacy—foreclosed the other—authenticity. In this way, self-silencing creates feelings of entrapment, isolation, and hopelessness. It is this dynamic, deeply tied to social context, that is hypothesized to foster depression.

With Gilligan’s encouragement, I redrafted my thesis for Harvard University Press, eager to communicate what seemed to be a way of understanding women’s depression that integrated the phenomenology of the inner world and the outer circumstances of their lives (Jack, 1991). Deborah Belle, also on my dissertation committee, suggested creating a measurement instrument that could be used to test the association of silencing the self with depression. The dissertation study was of a very small, homogeneous group of 12 women from the Pacific Northwest; clearly the ideas needed a means to be tested across diverse groups of women in different cultures and subcultures. The process of distilling the ideas into a well-validated research instrument felt daunting. I remain grateful for Deborah Belle’s supportive prompting and for co-graduate student Diana Dill’s generous contribution of her statistical skills and insights.

How could the complex phenomenology of silencing the self be captured by a measurement instrument? Approaching the creation of the scale as a theory-building exercise, I considered the major themes that reflected the dynamic of self-silencing in the women’s narratives. These became the four subscales of the STSS: Externalized Self-Perception (seeing and judging the self by external standards); Care as Self-Sacrifice (securing attachments by putting the needs of others before the self); Silencing the Self (inhibiting one’s self expression and action to avoid conflict and possible loss of relationship); and the Divided Self (presenting an outward self that differs from inner experience; the experience of inner division). The first subscale taps standards used for negative self-judgment; the second and third measure schemas governing interpersonal behavior; and the fourth reflects the phenomenology of depression. Subscales are interrelated and together form the construct of silencing the self; they are considered to work together in an interactive fashion so that as one aspect is endorsed, it heightens endorsement of the other three.

I took sentences almost verbatim from women’s narratives to illustrate these four themes, and respondents express their agreement or disagreement with the sentences on a 5-point Likert-type scale (see Jack, 1991, 1999b; Jack & Ali, 2010, for elaboration). The challenge was to craft statements that were straightforward enough to be used in a scale, but that also represented the complex set of ideas central to silencing the self theory. For example, depressed women’s statements such as “... my fear of standing up for myself because I could lose the relationship” (Jack, 1991, p. 118) or “... I got to the point where I thought my opinion was worth nothing ... and I thought, when this thing or that thing happened, I thought I won’t cause waves, I won’t say anything” (p. 137) were represented in Item #18, “When my partner’s needs or opinions conflict with mine, rather than asserting my own point of view I usually end up agreeing with him/her.” This item reflects a woman’s subjugation of her own concerns and aspirations and depicts an inauthentic agreement with her partner. The item is also constructed to demonstrate a person’s awareness that they are blocking their own needs or opinions in order to harmonize with their partner. The social support for this self-inhibition derives from the stereotype of the good woman and the inequality between the sexes, which reinforces the view that the man’s needs, wishes, and opinions are somehow more important or worthwhile.

In constructing the scale, my hope was that it would continually call attention to the social, interpersonal context of depression, particularly how social and gender inequality live in one’s mind to affect everyday interactions and the experience of self. The measure was also based on assumptions about the centrality of relationships in people’s lives and on the depressogenic effect of relational disconnection. I knew from feminist scholarship (Unger, 1983) that a research instrument creates a way of seeing; it does not just test a theory. It spotlights certain aspects determined to be important while other features fall into the shadows. In the 1970s and 1980s, research investigating depression relied primarily on diathesis–stress models that identified some preexisting, stable attribute of the personality or cognitive style presumed to interact with the environment to create depressive vulnerability (Beck, Rush, Shaw, & Emery, 1979; Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982; Nolen-Hoeksema, 1987). This perspective focused the spotlight more on the person than on the context. I wanted to highlight the context—more precisely, the effect of the context on a person’s relational schemas. The most straightforward way was to demonstrate that differences in social/relational contexts affected the endorsement of self-silencing.
Thus, for the study of scale construction published in *PWQ* (Jack & Dill, 1992), I had to test not only the reliability and validity of the scale but also whether social context mattered in terms of endorsement of the STSS. I thought that a between-groups design, with participants from three radically different social contexts, would be the best test. The three contexts were university students, women with children under age 3 who were participants in a study funded by the National Institute of Drug Abuse (NIDA) examining the effects of cocaine use on infant development, and women from three battered women’s shelters. From listening to depressed women’s voices, it was clear that in battering relationships, self-silencing was a survival strategy. Mean scores on the STSS among participants from battered women’s shelters should therefore be highest. I predicted that scores would be lowest among undergraduates who were rarely in long-term, committed relationships and whose university setting offered relative freedom from demands for self-silencing. Participants in the NIDA study should score in between these two extremes. The hypothesis that endorsement of the STSS would vary with the social context was upheld, as was the prediction that within each context, STSS scores would correlate with symptoms of depression.

The 1992 *PWQ* article was the first I published in a journal, with essential help from Diana Dill and colleagues at Western Washington University. Because of the wide readership of *PWQ*, others quickly brought their interests, creativity, and research acumen to widen the scope of inquiry using the scale. Two excellent studies published in *PWQ* brought further validation to the STSS: Linda Gratch (now Linda Vaden-Goad) and colleagues’ important validation study with a large multicultural sample (Gratch, Bassett, & Attra, 1995) and Janice Thompson’s (1995) examination of self-silencing in a community sample of married women and men. It was exciting to talk with these researchers and have their early, enthusiastic support for my ideas as well as see how they applied them in their research.

Now, 19 years later, STS theory and the STSS are alive in the literature and continuing to be published in *PWQ* even into the present issue (Shouse & Nilsson, 2011). The scale is in use in at least 22 countries, and it has been used in approximately 80 peer-reviewed journal articles and in numerous dissertations. The scale and accompanying theory have been used to investigate a wide range of mental and physical health issues and have been compared with other known variables associated with depression. Across investigations, levels of self-silencing vary with social context in predicted ways, with higher levels associated with variables indicating inequality and oppression. Self-silencing significantly associates with symptoms of depression in women and adolescents across a wide range of contexts and cultures. Subscales have been replicated in different samples of women (Cramer & Thoms, 2003; Duarte, & Thompson, 1999; Remen, Chambliss, & Rodebaugh, 2002; Stevens, & Galvin, 1995). Because a literature review focusing on gender, self-silencing, and depression is in preparation (Jack, Ali, Alichandra, & Gordon, 2011), I will turn from outlining work that has been done with the STSS to focus on the international work, current questions, and possibilities for future research.

### International Research on Self-Silencing and Depression

In 2000–2001, I was awarded a Fulbright fellowship to study gender, self-silencing, and depression in Nepal and to teach in a graduate women’s studies program at Tribhuvan University, Kathmandu. I wanted to learn if self-silencing contributed to depression in a culture that is explicitly male-dominated. I listened to depressed women’s and men’s stories of what had led up to their depression with specific questions in mind: Does the importance for mental health of having a voice in intimate relationships vary across cultures? Are the difficulties that lead people into self-silencing and depression similar across very different cultures? How do dominance and clear gender roles affect men’s depression? Working with Nepali psychiatrists in government outpatient clinics, I conducted qualitative and quantitative studies with people diagnosed with major depressive disorder (Jack, Pokharel, & Subba, 2010; Jack & Van Ommeren, 2007) and returned to Nepal several times to examine the meanings women and men attributed to the STSS scale items.

In these studies, I was also curious about men’s consistently higher scores on the STSS than women’s. Whereas self-silencing consistently associates with women’s depression symptoms, results are more complex and varied among men (Smolak, 2010). Some have argued that men’s higher STSS scores disconfirm Silencing the Self theory. Rather, I think this finding calls into question our attempt to understand gender through examining sex differences, affirms the importance of relationships for women and men, and suggests that men may be attributing different meanings to the STSS items than women. My speculations was confirmed in the Nepal studies and has recently been established in a mixed-method study of informal cancer carers in Australia (Ussher & Perz, 2010). These findings have led me to consider that Silencing the Self theory and the STSS may provide a perspective for understanding how the construct of gender constrains our ability to see the universality of the human need for relational connection. Can it help us learn about the effects of men’s suppression and/or disavowal of this need? How do norms of masculinity affect self-silencing? With these questions in mind, I am currently exploring men’s self-silencing and depression in a mixed-methods study. This investigation is being greatly enriched by Alisha Ali’s and Carol Gilligan’s instrumental help.

My experience in Nepal, as well as correspondence with researchers in other countries whose questions paralleled my own, provided the impetus for the book *Silencing the Self Across Cultures: Depression and Gender in the Social World*. .
(Jack & Ali, 2010). My coeditor Alisha Ali and I included chapters from researchers who lived in 13 different countries, and we asked them to include a brief sketch of women’s roles in each of their countries. The 21 chapters in this book, as well as other international studies, reveal that self-silencing carries harmful psychological effects for both women and men. This book also contains chapters on the negative physical health effects of self-silencing and on treatment approaches that support women’s voices. I think that the STSS works well across diverse cultures and contexts because it is based on the assumption that positive relationships are central to well-being, and that unequal contexts, particularly related to gender inequality, affect thought (schemas) and behavior for dominants and subordinates alike. Dichotomizing and enforcing gender expectations injures everyone’s freedom and well-being.

So many questions remain, particularly in light of work by others: What is the neurobiology of voice? In childhood, attention and language support neural growth and network integration, whereas trauma suppresses voice and affects loss of verbal memory (Van der Kolk, McFarlane, & Weisaeth, 1996). How do childhood and adult trauma affect self-silencing? Also, how does self-silencing affect the body; that is, what are the physiological correlates of self-silencing? For example, researchers are finding strong associations of self-silencing with coronary heart disease (Eaker & Kelly-Hayes, 2010; Eaker, Sullivan, Kelly-Hayes, D’Agostino, & Benjamin, 2007). What are other health effects of self-silencing?

What is the relationship of anger and aggression to self-silencing and depression? Anger stood out as an emotion that depressed women particularly tried to divert or disguise from others. Most women considered their anger to be aggressive and feared that it harmed closeness, yet their anger often exploded. Curious, yet finding little about aggression from women’s own voices, in the mid-1990s I investigated women’s anger and aggression in a qualitative study of 60 women, described in Behind the Mask (Jack, 1999a). Trying to learn more about depression through exploring women’s anger felt like entering a seldom used back door; it seemed more highly forbidden for women to move in and out of anger than depression. Only a handful of known studies have investigated the relation of anger to self-silencing and depression (Brody, Haaga, Kirk, & Solomon, 1999; Jack, 1999a, 2003; Tan & Carfagnini, 2008), yet anger suppression has been linked to numerous adverse psychological and physical consequences.

What are the mechanisms by which self-silencing leads to depression? We know that depression’s origins are multi-causal and that multiple pathways of mutual influence among psychological processes, physiology, and the social world together determine either psychological wellness or distress. Since the STSS was published, there has been an unparalleled convergence of neuroscience, evolutionary theory, and psychology that affirms the importance of positive relationships to human functioning. The brain itself is a social organ; its very structure and biology are shaped by social contexts and interpersonal interactions throughout life. These contexts affect the body/mind not only through neurochemical responses but also by assigning meaning to physical events and social interactions.

Self-silencing negates the self, disrupts connection, and leads to isolation and self-alienation. It appears that silencing the self interacts with a range of processes known to precipitate depression, such as a negative experience of self, a threat of separation that in turn engages the attachment system, and an activation of neurobiological systems and higher order self-regulatory cognition. Because relational disconnection constitutes a major threat to the self, self-silencing may be a crucial element in precipitating depression. How might self-silencing mediate or moderate between the conditions of the social context and depression? Prospective studies are necessary to shed light on such questions.

Finally, can the STSS provide a basis for clinical interventions with people diagnosed as depressed? I had hoped to develop a measure that would bridge the clinical and the research worlds. Because the cognitive schemas measured by the STSS are relational and also phenomenological (reflecting the experience of disconnection when one self-silences), I thought they could provide a basis for individual and group therapy (see Jack, 1991, 1999b; Jack & Ali, 2010). Currently, other researchers are developing models of intervention based on overcoming self-silencing—for example, with eating disorders and HIV/AIDS (see Jack & Ali, 2010).

Conclusion

The questions that have directed my research arose from life experiences that created a compelling desire to understand depression. The contexts that generate our questions matter, which is why having both feminism and a growing number of minority psychologists are critical for our field. The challenge for us as feminist scholars is to maintain a passionate attachment to our questions yet, at the same time, use tools that ensure objectivity in the testing and analysis of our questions. For me, the despair of depression deeply involves questions of value and meaning, culture and freedom. Searching the larger surround to understand depression and delving into questions of inequality, suffering, injury of the spirit, and limitations of Western diagnostic labels have always seemed critical. It appears even more critical now, particularly with the World Health Organization’s prediction that depression will become the second leading cause of the world’s disease burden by 2020 (World Health Organization, 2011). We need more than antidepressant medications to offset the rising incidence of despair; we need urgent social change along with new paradigms of depression.

The STSS grew from listening to depressed women’s voices. From them, I heard the pain and disconnection of imposed silence. Silence can be a marker of oppression, yet not all silence results from oppression. Self-silencing can be a positive act. It can occur out of freedom, when one
chooses not to speak or act in certain circumstances. The issue is freedom: self-silencing becomes destructive when a person perceives no choice.

It is voice that brings us into connection. We must remove the cultural norms and violence that lead to self-silencing if we are to achieve a world of greater equality and human fulfillment. My hope is that research identifying the causes and results of self-silencing will help shed some small light on a path leading in this direction.

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