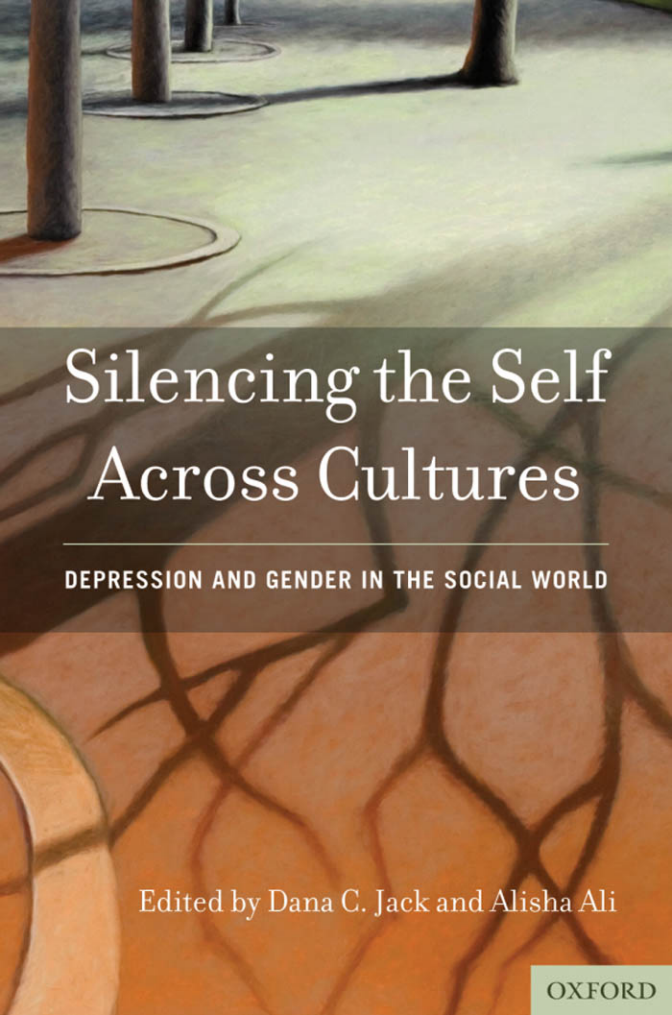
Silencing the Self
Across Cultures
DEPRESSION AND GENDER IN THE SOCIAL WORLD
Edited by Dana C. Jack and Alisha Ali
OXFORD

SILENCING THE SELF ACROSS CULTURES

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DEPRESSION AND GENDER IN THE SOCIAL WORLD

Dana Crowley Jack
Alisha Ali

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This book is dedicated, with love, to Rand,
to my children Darby and Kelsey, and to
my mother, Dorothy Beach.
Dana C. Jack

To Bruce, Talia, and Adara. And to my mother.
Alisha Ali

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Preface

Carol Gilligan

I remember the afternoon, the gray light, the feeling of snow. Dana Jack had come to talk about her dissertation, and we were sitting in my small office in Harvard's Schlesinger Library. We moved our chairs closer together to read through the transcripts Dana brought with her. She was studying depression in women, and she had interviewed clinically depressed women in the Pacific Northwest where she was living.

I remember the astonishment that ran through my body as I saw evidence of a first-person voice speaking in the midst of depression, an "I" saying, "I want . . . I know . . . I see . . . I feel . . . I think . . . .I believe." Woven through the fabric of listlessness, lifelessness, helplessness, and hopelessness were signs of a self, active and present—but a self beset by a second voice, the voice of what Dana would call the "Over-Eye," an internalized observer who watched, judged, condemned, and ultimately silenced the self. In no uncertain terms, it assumed moral authority, often backed by religious sanction, addressing the self typically in second or third person, saying, "You should . . . .one ought," and establishing how a good woman would act, what she should do. Above all, it enjoined a woman to be "selfless," to care for others and maintain relationships without speaking about or for herself. With stunning insight, Dana reframed the dynamics of depression. The exhaustion of depression reveals the energy it takes to silence the self.

In "Mourning and Melancholia," Freud attributed depression to a failure of mourning, an evasion of sadness in the face of loss. "The shadow of the object falls on the ego," he wrote. Today, depression is more commonly seen as reflecting a fault in brain chemistry, a consequence of genetic predisposition or trauma or a sequel to unfortunate life circumstances such as poverty or illness. In either case, the depressed person is rendered helpless, a victim of neurochemistry and/or fate. The mind, seen as part of the body, is treated for the most part pharmacologically. In the study of depression, serotonin reuptake inhibitors have replaced the analyst's couch.

In this light, we can appreciate the contribution of the essays collected in this volume. By listening to women and hearing the inner dialogue of depression, Dana Jack had found evidence of an active and ongoing, if losing, battle on the part of the self against the voices that would render her silent or silenced. In doing so, she picked up the moral themes in women's depression, recognizing in the voice of the Over-Eye, a culturally scripted voice. Bringing a cultural perspective to the analysis of women's depression, she also saw the bind women were caught in: To contest the voice that would silence her in the name of goodness, a woman would render herself, in its terms, selfish, bad, and wrong. Thus, she was trapped in a circle of self-condemnation; to break free meant to challenge the culture in which she was living, a framework that encompassed herself. The authors who speak in this book have done just that: challenged their native cultures by calling attention to the various ways in which they silence women, precipitating depression or causing women who resist self-silencing to struggle against feeling bad or wrong or selfish or crazy. The writing of these essays becomes a courageous act of resistance against those who would enforce or collude in women's self-silencing and thus countenance the near-epidemic rates of depression among women.

The range of cultures represented here attest to the ubiquity of pressures on women to render themselves selfless by caring for others and maintaining relationships while silencing themselves. The moral themes in women's depression expose and enforce the gender binaries and hierarchies of a patriarchal social order, where being a man means not being a woman and also being on top. To be a good woman, good wife, good mother, good daughter, good helpmate or colleague, a woman must subordinate herself to male authority and accede to the voice or the law of the fathers.

The stark implication of the self-silencing theory of women's depression is that the self does not go gently into silence. Whatever its biological substrates or sociological precipitants, depression in women is also a sign or a symptom of a woman's resistance to silencing herself. However costly or misguided, it is a resistance to the gender binaries and hierarchies of patriarchy. The etymology of the word "hierarchy," literally meaning a rule of priests, reveals the religious substrate of patriarchy, an order of living in which the *hieros*, the priest, is a *pater*, a father. The dynamics of depression thus become inseparable from the tensions between democracy and patriarchy, one grounded in equality of voice, the other privileging the voices of fathers. The resistance of the "I," the voice of the self, to the voice of the Over-Eye, the internalized voice of patriarchal authority, is a fight for voice and for relationship that is also a fight for love and democracy.

I want to pause for a moment to speak of methodology, because the exploration of depression that began with Dana listening to the voices of depressed women with an ear for the culture in which they are living is a model for how to proceed from qualitative analysis to quantitative research. With the

development of the Silencing the Self Scale, it became possible to take a theory grounded in the voices of depressed women and explore its explanatory power in wider populations across a range of societies and cultures. The refinement and validation of the self-silencing theory of women's depression is among the more impressive achievements of contemporary psychological research, revealing a sophistication of method and also the power of a theory that integrates cultural perspectives in seeking to explain a major, worldwide problem in public health. It becomes a model for research that is at once experience-near or culturally thick, in Clifford Geertz's terms, and scientifically powerful in its ability to predict and explain.

At the core of the self-silencing theory of depression, the contradictions between relationship and subservience become unmistakable. Voice is integral to relationship, a sign of being present and engaged with others. Just as voice depends on resonance and as speaking depends on listening and being heard, so, too, without voice, there is no relationship, only the chimera of relationship. But as voice is grounded both in the body and in language, it roots psychology within biology and culture without reducing it to either. The counterpoint of voices in women's depression, the inner dialogue between the "I" and the Over-Eye, underscores the need for a theory of depression that encompasses not only biology but also the subjectivity of women and the power of the forces that would render them silent or silenced. The paradox at the center of the self-silencing theory of depression is that in the name of caring for others and maintaining relationships, a woman must in effect sacrifice relationship and abandon herself. Women's depression thus becomes a protest against the loss of voice and relationships, a way of saying, "I have been silenced."

Reflecting on the epidemiology of depression, Martin Seligman reminds us that during childhood, boys are more often depressed than girls. It is in adolescence that this pattern reverses, with the sharp rise in the incidence of depression among girls extending into womanhood and leading to the common observation that women are more often depressed than men—or at least are more likely to display depressive symptoms and be diagnosed as such. Depression itself with its listlessness and passivity is often seen as antithetical to masculinity. Reading Seligman, I was intrigued by his observation that whatever causes the gender flip-flop in the incidence of depression, with women becoming twice as depressed as men, it does not have its roots in girls' childhood. Something must happen to girls in adolescence, he concludes, to account for the sudden shift.

The studies of girls' development that my colleagues and I began in the 1980s offer an explanation, derived from a close listening to girls' narratives of coming of age. Approaching adolescence, girls describe a crisis of relationship as they face pressures from without and within to choose between having a voice and having relationships. As 16-year-old Iris says, reflecting on the outspokenness of younger girls, "If I were to say what I was feeling and thinking, no one would

want to be with me, my voice would be too loud." Thirteen-year-old Tracy observes, "When we were 9, we were stupid." But when I say that it would never have occurred to me to use the word "stupid" since what struck me most about her and her classmates when they were 9 was how much they knew, she says, "I mean, when we were 9, we were honest." As an honest voice comes to seem or to sound stupid, girls begin to silence themselves. But they can also discern the rationale for this self-silencing, its justifications, and its adaptive value within societies or cultures where women's honest voices often sound too loud and are called stupid or crazy or bad or wrong. The dynamics of women's depression are built into the structures of patriarchy, giving rise to a tension between psychology and culture, between the desire to speak and pressures to silence oneself because, as Iris explains, "you have to have relationships."

The startling discovery made by listening to girls is that at adolescence, girls have the cognitive capacity to describe and reflect on their initiation into the codes and scripts of patriarchal womanhood. Thus, they signal the onset of dissociation: the splitting of mind from body, thought from emotion, and self from relationships, leading to a loss of voice and signs of psychological distress. Listening to girls and observing their passage from childhood to adolescence sparked the realization that the initiation into the gender codes and scripts of patriarchy bears some of the hallmarks of trauma: loss of voice, loss of memory, and consequently, loss of the ability to tell one's story accurately. Once a woman has internalized the norms and values of a patriarchal order that requires her to care for others while silencing herself, she finds herself, in the words of Jean Baker Miller, "doing good and feeling bad."

The analysis of women's depression as a manifestation of self-silencing when joined with research on girls' development suggests that women's voices may hold a key to resolving a long-standing puzzle in research on human development, a puzzle highlighted by the epidemiology of depression. The fact that boys show more signs of psychological distress during childhood, including a higher incidence of depression, can be seen to reflect their earlier initiation into the gender binaries and hierarchies of patriarchy, leading them to hide or deny the vulnerability of their bodies, to suppress emotions that imply tenderness or softness, and to construct a self that is separate from relationships. In doing so, they compromise their emotional intelligence and diminish their capacity to read the human world around them. In essence, they sacrifice relationship for hierarchy in claiming patriarchal masculinity and silence vital parts of themselves. Tenderness, relationships, and the vulnerable body become the domain of women, at once idealized and devalued, while toughness, self, and rationality are elevated and associated with masculinity.

In resisting these inner divisions, women may give voice to what men cannot say without placing their manhood in jeopardy. To the extent that women resist self-silencing, they are resisting an initiation that is costly for men as well. The study of women's depression thus highlights what is ultimately a human

problem, a conflict between healthy psychological development and the culture of patriarchy with its associated ills of racism, sexism, homophobia, and other forms of intolerance. In *The Deepening Darkness: Patriarchy, Resistance, and Democracy's Future*, David Richards and I observe, "what patriarchy precludes is love between equals and thus it precludes democracy, founded on such love and the freedom of voice it encourages" (p. 19).

The signal contribution of the essays gathered here by Dana Jack and Alisha Ali is that by bringing cultural perspectives to the analysis of depression in women, they reveal the overarching framework of patriarchy. To see the framework, however, is also to reveal the possibility of shifting the frame. By joining women in their resistance to self-silencing and showing the costs of inequality, the authors of these essays link the study of depression to a call for democratic forms of living and functioning. The requisites for love—having a voice and living in relationships—are also the requisites for democracy. The fact that we, men and women alike, are born with a voice and into relationship means that we have within ourselves the capacity for love and for citizenship within democratic societies. To see depression as a sign of self-silencing is to recognize the costs of perpetuating patriarchal norms and values in all their subtle and not so subtle manifestations. The worldwide pervasiveness of depression in women is a flag, drawing attention as well to the more hidden symptoms of depression in men. My hope is that this will be the first in a series of books on depression that expose the costs of self-silencing, releasing in both women and men a voice of ethical resistance to perpetuating or justifying, in the name of morality, a history of trauma, tragedy, and violence.

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Contents

Section II

Contributors

Alisha Ali, PhD, Department of Applied Psychology, New York University, New York

Jill Astbury, PhD, School of Psychology, Victoria University, Melbourne, Australia

Clelia Beltrame, BS, Center for Addictions Research and Services, School of Social Work, Boston University, Boston, Massachusetts

Guillermo Bernal, PhD, Department of Psychology, University of Puerto Rico, Centro Universitario de Servicios y Estudios Psicológicos, San Juan, Puerto Rico

Avi Besser, PhD, Department of Behavioral Sciences, Chairman, Center for Research in Personality, Life Transitions, and Stressful Life Events, Sapir College, D.N.H. of Ashkelon 79165, Israel

Laura S. Brown, PhD, Fremont Community Therapy Project, Seattle, Washington

Stephanie Cassin, PhD, Department of Psychiatry, Sunnybrook Health Sciences Centre, University of Toronto, Toronto, Ontario, Canada

Rosanna F. DeMarco, PhD, PHCNS-BC, ACRN, FAAN, William F. Connell School of Nursing, Boston College, Chestnut Hill, Massachusetts

Krystyna Drat-Ruszczak, PhD, Warsaw School of Social Psychology, Warsaw, Poland

Elaine D. Eaker, ScD, Eaker Epidemiology Enterprises, Gaithersburg, Maryland

Gordon L. Flett, PhD, Faculty of Health, York University, Toronto, Ontario, Canada

Josie Geller, PhD, Eating Disorders Program, Department of Psychiatry, University of British Columbia, Vancouver, British Columbia, Canada

Carol Gilligan, PhD, Department of Applied Psychology, New York University, New York

Richard A. Gordon, PhD, Bard College, Annandale-on-Hudson, New York

Airi Hautamäki, PhD, Swedish School of Social Science, University of Helsinki, Helsinki, Finland

Susanne Hedlund, PhD, Center for Behavioral Medicine, Roseneck Hospital, Prien am Chiemsee, Germany

Paul L. Hewitt, PhD, Department of Psychology, University of British Columbia, Vancouver, British Columbia, Canada

Bridget Hirsch, MA, Department of Counseling, Developmental, and Educational Psychology, Lynch School of Education, Boston College, Boston, Massachusetts

Dana Crowley Jack, EdD, Fairhaven College of Interdisciplinary Studies/ Western Washington University, Bellingham, Washington

Judith Jordan, PhD, Jean Baker Miller Training Institute, Lexington, Massachusetts

Margaret Kelly-Hayes, EdD, RN, FAAN, School of Medicine, Boston University, Boston, Massachusetts

Natasha S. Mauthner, PhD, Business School, University of Aberdeen, Aberdeen, Scotland

Maria I. Medved, PhD, Department of Psychology, University of Manitoba, Winnipeg, Manitoba, Canada

Sofia Neves, PhD, Departamento de Psicologia, Instituto Superior da Maia, Maia, Portugal

Guerda Nicolas, PhD, Department of Educational and Psychological Studies, University of Miami, Miami, Florida

Conceição Nogueira, PhD, Instituto de Educação e Psicologia, Universidade do Minho, Minho, Portugal

Janette Perz, PhD, Gender, Culture and Health Research Unit, School of Psychology, University of Western Sydney, Sydney, Australia

Bindu Pokharel, MA, Central Department of Rural Studies, University Campus, Tribhuvan University, Kirtipur, Nepal

María R. Scharrón-Del Río, PhD, School Counseling Program, Brooklyn College, New York

Anjoo Sikka, PhD, College of Public Service, University of Houston – Downtown, Houston, Texas

Linda Smolak, PhD, Department of Psychology, Kenyon College, Gambier, Ohio

Mary Sormanti, PhD, MSW, School of Social Work, Columbia University, New York

Suja Srikameswaran, PhD, Eating Disorders Program, Department of Psychiatry, University of British Columbia, Vancouver, British Columbia, Canada

Janet M. Stoppard, PhD, Department of Psychology, University of New Brunswick, Fredericton, New Brunswick, Canada

Usha Subba, PhD, Department of Psychology, Trichandra Multiple Campus, Tribhuvan University, Kathmandu, Nepal

Joseph E. Trimble, PhD, Department of Psychology, Western Washington University Bellingham, Washington

Jane M. Ussher, PhD, Gender, Culture and Health Research Unit, School of Psychology, University of Western Sydney, Sydney, Australia

Linda (Gratch) Vaden-Goad, PhD, School of Arts and Sciences, Western Connecticut State University, Danbury, Connecticut

Lisa K. Waldner, PhD, Department of Sociology, University of St. Thomas, St. Paul, Minnesota

Stephanie J. Woods, PhD, MSN, College of Nursing, University of Akron, Akron, Ohio

Judith Worell, PhD, Department of Education and Counseling Psychology, University of Kentucky, Lexington, Kentucky

Tanja Zoellner, PhD, Center for Behavioral Medicine, Roseneck Hospital, Prien am Chiemsee, Germany

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Foreword: Silence No More

Judith Worell

I am honored and excited to share in the publication of this important volume. The editors have gathered an outstanding group of distinguished authors who present us with a range of national and international research supporting and expanding the utility of the Silencing the Self Scale (STSS). The diversity of perspectives on the culture/depression formulation is clearly enhanced by the inclusion of a single measure across research localities. Through binding together theory, assessment, and cultural awareness, we gain further access to the critical role of context in relation to women's emotional distress. Inclusion across chapters of both quantitative and qualitative approaches honors a flexibility model of research methodology that can unlock new insights on old concerns. Across the centuries of recorded history, depression has not disappeared from the human condition, and women continue to be the major recipients of its malaise. The chapters in this volume that document women's disempowerment globally can offer us further guideposts to the possibilities for change. Their messages speak to many minds and hearts, stimulating further research by opening new vistas across nationalities and cultures.

My original involvement in publication of the STSS (Jack & Dill, 1992) dates back to the time I was editor of the *Psychology of Women Quarterly* (PWQ). Due to my clinical training, practice, and research, this article carried a special historical significance for me. Since its inception in 1976, the journal served as a beacon of light that illuminated and explored the factors that influence the lives and well-being of women. It was exhilarating to be in the position of publishing high-quality articles that welcomed discussions of feminist theory and research. The articles that were published in PWQ opened doors to our knowledge and understanding of the critical role of gender, context, and a range of diverse social locations in women's lives. Although the psychology of difference was only one of many topics welcomed by the journal, I was particularly intrigued by this creative research that addressed the gender imbalance in rates of emotional distress and depression with convincing data. From my past clinical experience

with women's concerns in counseling and psychotherapy, expressions of anxiety, hopelessness, and depression were among those I most frequently encountered with clients. For many clinicians, our understanding of gender dynamics was limited to a few prevailing theories that frequently tended to place blame on the woman for her concerns. In contrast, creative hypotheses and supporting data that connected client distress to broader gendered contexts were certainly a welcome addition to the journal. As this volume on the STSS so clearly articulates, the context of women's well-being or distress is reflective of the larger social milieu and cultural norms that are embedded in each particular historical time and location.

In the public arena at that time, attention to the status of women in the United States was at midstream. Federal legislation had been enacted to establish educational and employment equity, but public commitment to women's psychological health concerns lagged far behind. The importance of women's access to graduate education and professional development to research on female health cannot be underestimated. In contrast to historical invisibility or a sex-difference approach to well-being, an increased cadre of women researchers began to ask new questions about women's lives and experiences. As Barbara Wallston (1981) so eloquently wrote: "What are the questions in the psychology of women?" With this statement, she helped to reframe the research agenda away from contrived laboratory experiments toward a feminist perspective on the context of women's real lives and their "lived" experiences. For many of us, personal experiences lay the groundwork for how we proceeded with our science and what topics we chose to investigate. This was true of me as well. What was life like for women growing up before the middle of the last century? I take myself as an example.

As was typical for many young children, my early experience of gender disparities was situational and personal. In my world, girls seemed to have different rules than boys for how we dressed, how we spoke, and how we behaved at home, in school, and in public places. That boys might have a better deal than girls was also interpreted through a personal lens in particular situations related to visibility and voice. I noticed and asked questions, but seldom complained about what appeared to be the "natural order." Why did my brother have more freedom than I to go places alone? Why did the boys and men in my parents' temple sit downstairs to pray while the women and girls sat upstairs behind a screen where they remained unheard and unseen? Why did women and girls prepare, serve, and clean up after meals while boys went out to play and men sat reading the newspaper? And why was my mother reserved and apparently compliant at home but openly expressive when we were together or among her women friends? My awareness that these cultural and family rules were replicated in some form across many situations emerged only gradually. In graduate school, I continued asking questions as it became more evident that such gender divisions were trans-situational and entrenched within larger social

structures. Why were there 18 men and only 2 women in my entering class? Why was the psychology department in this major university composed of 40 male but no female faculty? In those days, women students had few or no professional role models and no mentors to help them navigate the narrow halls of academia. Later experiences of exclusion were denial of faculty status in several male-only academic departments. Being the first and only woman faculty in four other institutions was affirming but also isolating. That my exclusion from the ivory tower was not personal but social and political became evident in the following years.

During the 1960s, rumblings of a revitalized women's movement broke into my silence. Invited to join a women's conscious-raising group, I discovered another world of possibilities. We read the outrageous ideas of Betty Freidan (1963) and Robin Morgan (1970), with the empowering conclusion that "the personal is political." We began to understand that the rules by which we had been living were embedded in the social, economic, and political arrangements of the larger culture. And so along with many other "foremothers," I became actively involved in what was known at the time as the Women's Liberation Movement. We were to be freed from restrictive gender-based social roles, with the attending responsibility to bring knowledge of this freedom to all women.

Of course, we know that radical change does not come easily or without a price. From many directions, both public and professional, came outrage and denial. In response to the backlash against "mouthy aggressive women libbers," I coauthored a research study on the personalities of women and men college students who supported or rejected the movement for women's legal, political, and economic equality. We were pleased to report no evidence of deviant personality for supporters on any of our measures. Instead, we found that women supporters were more autonomous (self-directed) than nonsupporters, and male supporters more cognitive and thoughtful. We presented our findings in a symposium at the American Psychological Association's annual convention that included data from psychologists, an economist, and a civil rights attorney (Worell & Worell, 1971, 1977). As some of the earliest research on this topic, the symposium attracted an overflowing audience; we knew we were on the right track.

At the same time, small groups of psychologists organized to support larger social and economic efforts. They insisted (although unsuccessfully) that state psychological associations meet only in states that had ratified the Equal Rights Amendment to the U.S. Constitution. They started their own independent organization (AWP, Association for Women in Psychology). They lobbied the American Psychological Association successfully to add a new Office of Women's Affairs, and a new APA Division (35) on the Psychology of Women. These groups breathed life and energy into many women who were yearning for professional inclusion and expression. As social scientists, we know that values and behaviors are mutually interactive; by increasing a valued activity,

commitment to the values supporting these activities can be further strengthened. And so it was for me. I became increasingly active with groups dedicated to supporting and empowering women. The well-being of girls and women has since directed my life efforts, a fortunate and rewarding decision.

When I served subsequently as editor of *The Psychology of Women Quarterly*, I noted a paucity of submitted manuscripts that explored variables related to women's psychological illness or health. It is intriguing to speculate about the reasons for this intellectual and research void, but among them may be the historical lack of recognition and institutional support for research on women's health in general. Imagine my enthusiasm when I read the validation study submitted by Dana Jack and Diana Dill on a new scale related to women's psychological well-being, the *Silencing the Self Scale: Schemas of Intimacy Associated with Depression in Women* (Jack & Dill, 1992). Contemporary research on the antecedents and correlates of women's vulnerability to depression was still in its infancy. Of particular interest to me in this manuscript was the proposed theoretical connection between how "social/gender inequality is structured in thought to affect everyday interactions" (Jack & Dill, 1992, p. 98) and the hypothesized cognitive schemas related to women's vulnerability to depression. There were many other hypotheses available to account for the gender discrepancy in the epidemiology of depression, but this article suggested an intriguing new direction. Further, the authors tested their cognitive schema hypothesis with a between-groups design that supported the concept of the self-silenced voice. Needless to add, the journal published the article. I have since recommended the STSS to a number of my doctoral students and clinical supervisees as a useful tool for both research purposes and clinical understanding.

During the period in which women in general were facing exclusion and sidelining, women of color and diverse cultures were even more invisible. Women from nonmajority groups voiced concerns (and at times outrage) at their marginal status in feminist psychology, pointing to the dimensions of multiple identity that characterize each of us as women (Landrine, 1995). Rather than ignoring, isolating, or problematizing minority groups, a multicultural psychology movement brought group and cultural diversity from the margins to center. The multicultural movement offered us new perspectives on the importance of considering the multiplicity and intersects of personal and social identities on women's well-being (Comas-Diaz & Greene, 1994; Robinson & Howard-Hamilton, 2000; Worell & Remer, 2003). A significant strength of this volume on silencing the self acknowledges and highlights the critical role of cultural context on women's experience and expression of depression.

Since the publication of the 1992 STSS validation study, a wide range of research has supported a number of competing hypotheses for the continued gender discrepancy in measures of depression. Perhaps each of them deserves a place in our consideration and possibly each of them holds some validity for some individuals. It remains to be seen whether any of them can match the

diversity of nationalities and cultural identities encompassed by the authors included in this impressive volume.

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Setting the Stage: Social, Biomedical, and Ethical Issues in Understanding Women's Depression

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Introduction: Culture, Self-Silencing, and Depression: A Contextual-Relational Perspective

Dana C. Jack and Alisha Ali

In this volume, authors from 13 countries present new insights about women's depression. Our goal is to join the collective effort to understand the complex problem of depression and to raise new questions from international perspectives. We rely on a model called Silencing the Self (Jack, 1991, 1999), which highlights the way people think about themselves and interact in their intimate relationships, specifically around the themes of voice and silence. Contributors to this volume come from Australia, Canada, Finland, Germany, Haiti, India, Israel, Nepal, Poland, Portugal, Puerto Rico, Scotland, and the United States. Each of the authors or coauthors lives in or originates from the country under investigation and thus writes about depression and self-silencing from a position of deep cultural knowledge. Because self-silencing also has implications for prevention, self-care, and recovery from illnesses other than depression, this book also addresses such conditions as HIV/AIDS, cancer, eating disorders, and cardiovascular disease.

The idea for this collection emerged from my (Dana Jack) work as a Fulbright scholar in Nepal in 2001. I was privileged to teach in Tribhuvan University's graduate program in Women Studies and to collaborate with Nepali psychiatrists on a study of gender and depression in Kathmandu. In government outpatient clinics, I listened to clinically depressed women's and men's stories about the onset and expression of their illness. Though the cultural context was vastly different from my own, I heard familiar themes of self-silencing as they described their depression.

Nepal's society is bound together by family relationships, duty, and spiritual beliefs in a world ordered by gods and fate. Elaborate rituals and traditions organize daily life. At the same time, extreme poverty and political instability

shadow this beautiful, diverse mountain country. Studying depression while immersed in Nepal's complex culture led to questions that created the international focus of this volume. Does the importance for mental health of having a voice in intimate relationships vary across cultures? How do widely divergent cultural norms affect the dynamics of self-silencing and gender? Are the difficulties that lead women into self-silencing and depression similar across cultures?

In the Women Studies program, working with faculty and students who pursue gender equality for Nepal's women, I saw how women exercise far less power in society and in the family than men. Women's silence about their own needs is a basic premise of Nepal's collectivist social structure. I started to wonder, How do religion, tradition, and governmental policies affect one's experience of self in intimate relationships?

At the same time that I became absorbed with such questions, international researchers were emailing me about their work on depression. They, too, were raising questions posed by their examination of voice and silence related to depression. As their questions joined mine, it seemed that addressing self-silencing across different cultures could contribute to understanding more about the causes of depression and ways to alleviate it. What might we learn from broadening the framework of inquiry beyond the dominant models through which we have understood depression? Alisha Ali, my coeditor, added her energies to this endeavor, and the idea of this book became a reality.

I (Alisha Ali) came to this idea of a cross-cultural account of self-silencing through my work interviewing women in various parts of the Caribbean about depression, silencing, and identity. In this work, I mostly interviewed women living in impoverished conditions who lacked the material comforts that many take for granted. And yet these women did not score high on my depression measures, nor did they seem at all depressed. What protected them against depression despite their impoverished living conditions? In talking to them, I realized that they had a strong sense of self and strong voices that allowed them to express themselves freely within their immediate circle. Additionally, they did not think of themselves as particularly disadvantaged, mostly because everyone they knew lived in similar circumstances—the social comparison of "have" and "have not" was not part of their daily experience. Furthermore, the women were the social and practical leaders in their communities, so they were respected and listened to. Their collective experience of "voice" was one of self-assurance and mutual empowerment. Talking to these women and observing them in their daily lives, I began to think about voice as the embodiment of one's culture: If you're in a culture that allows you to feel that your voice matters, then you feel that you, as a person, matter. So, in thinking about self-silencing across cultures, I was curious about what other cultural settings looked like in this respect. To get a snapshot of that would require a collection of writers describing silencing, women's roles, and the meaning of voice within their respective cultures.

Silencing the Self Theory: A Brief Overview

Because studies in this edited book rely on the Silencing the Self (STS) model and its accompanying measure, the Silencing the Self Scale (STSS) (Jack & Dill, 1992), we present the model here. STS theory is based on a longitudinal study of clinically depressed women's descriptions of their experiences (Jack, 1991, 1999, 2003), including their understanding of what led up to their depression. The women detailed how they began to silence or suppress certain thoughts, feelings, and actions that they thought would contradict their partner's wishes. They did so to avoid conflict, to maintain a relationship, and/or to ensure their psychological or physical safety. They described how silencing their voices led to a loss of self and a sense of being lost in their lives. They also conveyed their shame, desperation, and anger over feelings of entrapment and self-betrayal.

Though this process feels personal to each woman, it is in fact deeply cultural. A male-centered world tells women who they are or who they should be, especially in intimate relationships. Self-silencing is prescribed by norms, values, and images dictating what women are "supposed" to be like: pleasing, unselfish, loving. As I (Dana Jack) listened to the inner dialogues of depressed women, I heard self-monitoring and negative self-evaluation in arguments between the "I" (a voice of the self) and the "Over-Eye" (the cultural, moralistic voice that condemns the self for departing from culturally prescribed "shoulds"). The imperatives of the Over-Eye regarding women's goodness are strengthened by the social reality of women's subordination—the experience of being a target of male violence, and the difficulties of financial dependence and poverty. Women's inner arguments about how they should act and feel revealed a divided self that results from self-silencing in an attempt to preserve relationships. Inwardly, they experienced anger and confusion while outwardly presenting a pleasing, compliant self trying to live up to cultural standards of a good woman in the midst of fraying relationships, violence, and lives that were falling apart.

As I followed the negative self-evaluation (words like "no good" and "worthless") in their narratives, it became clear that women's self-judgment and behavior were guided by specific beliefs about how they should act and feel in relationships. When followed, these self-silencing relational schemas create a vulnerability to depression by directing women to defer to the needs of others, censor self-expression, repress anger, inhibit self-directed action, and judge the self against a culturally defined "good woman." In tandem with women's wider social inequality, such beliefs can keep a woman entrapped in negating situations as she blames herself for the problems she encounters.

In order to measure self-silencing, I designed the Silencing the Self Scale (Jack, 1991; Jack & Dill, 1992; Appendix A), a 31-item self-report instrument. The STSS reflects the components of relational schemas held by depressed women. The statements that comprise the scale came directly from the narratives of clinically depressed

women, yet are gender neutral. Respondents endorse each statement on a 5-point scale ranging from strongly disagree to strongly agree. Four rationally derived subscales measure the relational schemas central to self-silencing, and each is understood as an interrelated component of the overall construct. The subscales are considered to reflect both phenomenological and behavioral aspects of self-silencing:

1. Externalized Self-Perception assesses schema regarding standards for self-judgment and includes the extent to which a person judges the self through external standards. For example, item #6 reflects seeing the self through others' eyes: "I tend to judge myself by how I think other people see me." The last sentence on the STSS, item #31, reads, "I never seem to measure up to the standards I set for myself." Immediately following this item, the questionnaire instructs, "If you answered the last question with a 4 or 5 [agree or strongly agree], please list up to three of the standards you feel you don't measure up to." This allows for continuing investigation concerning the standards depressed individuals use to judge the self, including gender- and culture-specific standards.
2. Care as Self-Sacrifice measures the extent to which relationships are secured by putting the needs of others ahead of the needs of the self. For example, if a woman strongly endorses item #4, "Considering my needs to be as important as those of the people I love is selfish," then that belief directs her vision of the hierarchy of needs within relationships; it guides behavior by directing how she should choose when her needs conflict with those of others she loves; and it provides a standard for negative self-judgment if she veers from its command. Further, it can arouse anger as, following its dictates, she places her needs second to those of others, yet it also commands the repression of anger by purporting a moral basis for the suppression of her own needs. It reinforces a woman's low self-esteem by affirming that she is not as worthy or important as others, and finally, it legitimizes the historical and still prevalent view of women's nature as essentially self-sacrificing and maternal (Jack, 1991, p. 123).
3. Silencing the Self assesses the tendency to inhibit self-expression and action in order to secure relationships and to avoid retaliation, possible loss, and conflict. Item #8, which is reverse-scored, reads, "When my partner's needs and feelings conflict with my own, I always state mine clearly." The items in this subscale measure both behavioral and phenomenological aspects of self-silencing, as in item #30: "I try to bury my feelings when I think they will cause trouble in my close relationship(s)."
4. Divided Self measures the extent to which a person feels a division between an outer "false" self and inner self resulting from hiding certain feelings and thoughts in an important relationship. In women, it appeared that the false self was characterized by a mode of relating through compliance to the partner's wishes, and that the feelings hidden were oppositional or angry, challenging ones, as in item #16: "Often I look happy enough on the outside, but inwardly I feel angry and rebellious."

The STSS was validated in three groups of women in radically differing settings: undergraduate women, mothers who abused drugs and were caring for young children, and a battered women's shelter group. Results demonstrated not only that STSS scores correlated with scores on the Beck Depression Inventory

but also that STSS means varied with contexts in predicted ways. Participants' means in the three groups of women differed significantly from each other, with self-silencing highest among residents at battered women's shelters, intermediate among mothers who abuse drugs, and lowest among undergraduate participants. Across subsequent investigations, higher levels of self-silencing have been found to be associated with variables representing inequality, oppression, and other threats to self and relationships (Jack, Ali, & Alimchandani, 2010).

How Silencing the Self Theory Relates to Other Psychological Theories of Depression

The Silencing the Self model integrates aspects of attachment theory, relational theories, and cognitive theories of depression to explain women's vulnerability to depression. Given the impact of social disadvantage on emotional health, how might women's beliefs about how to make and maintain intimacy contribute to their vulnerability to depression? According to the attachment perspective, depression is interpersonal for both genders. Attachment theory (Bowlby, 1969, 1973, 1980) details the importance of relationships in human development and the impact that negative or insecure relationships have on functioning (see also Laurent & Powers, 2007; Mikulincer & Shaver, 2007). Confirmed by neuroscientific findings (Cacioppo, Visser, & Pickett, 2006; Cozolino, 2006), attachment theory describes that not only children but also adults have a basic, biosocial motivation to make secure, intimate connections with others. The mind is "wired for connection" (see Jordan, this volume), and throughout life, threats to relationships or social belonging set off a neural alarm network that warns of social separation (Eisenberger & Lieberman, 2004). When social relationships are threatened, the "social attachment system" (Panksepp, 1998) recruits attention and coping resources to prevent the threat of social exclusion or separation. Threats, such as relationships that are not secure or are demeaning, intensify specific attachment behaviors such as proximity seeking and reassurance seeking (Coyne, 1976; Joiner, Alfano, & Metalsky, 1992). The STS model proposes that such threats activate a set of specific attachment behaviors directed by the self-silencing relational schemas. Bowlby (1980) asserted that, in depression, "... the principal issue about which a person feels helpless is his [sic] ability to make and to maintain affectional relationships" (p. 247). From this perspective, relational disconnection and isolation are central to precipitating and maintaining depression.

Self-silencing relational schemas include a socially approved collection of "feminine attachment behaviors" (Jack, 1991) that can be described as "compliant connectedness" (p. 40). These behaviors are characterized by compulsive caretaking, pleasing others, and avoiding conflict by self-silencing. The behaviors resemble anxious attachment in their focus on the partner and in concern

about securing the relationship. The self-silencing relational schemas are readily available in the culture. They are heightened in social contexts that endanger a woman or that make a woman dependent on a particular relationship for her (and her children's) economic security.

Interestingly, while stressing the social nature of mind and experience, Bowlby and many attachment theorists have overlooked the fundamental patterning of gender on consciousness and interpersonal behavior. Relational theory formulated from a feminist perspective (Gilligan, 1982; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Miller, 1976) fills this gap, describing how women, as unequals to men, are more attuned to the quality of relationships and more likely to function as relationship "barometers" than men (Floyd & Markman, 1983). These writers stress that intimate relationships are critical for women's sense of self. Women's depression is understood as tied to the importance women place on the quality and maintenance of their relationships.

A large body of work affirms that women's gender inequality plays a significant role in their depression. Because of inequality, women experience higher exposure to social stresses known to foster depression, such as poverty, war, victimization, economic dependence, and lack of control over childbearing (Broadhead & Abas, 1998; Patel, 2001; Patel & Kleinman, 2003; Patel, Abas, Broadhead, Todd, & Reeler, 2001). Strikingly similar research findings around the world point to the importance of negative, humiliating, entrapping interpersonal events that join social stresses in precipitating women's depression (see Broadhead, Abas, Sakutukwa, Chigwanda, & Garura, 2001; Brown, 1998, 2002; Brown & Harris, 1978; Brown, Harris, & Hepworth, 1995; Kessler, 2003; Patel et al., 2001). Society affects not only a woman's power and prerogatives in relationships but also her ability to escape harmful circumstances, including psychologically damaging and/or violent relationships (Cabral & Astbury, 2000; Trivedi, Mishra, & Kendurkar, 2007). Social values and social structures, then, reinforce the notion of women's devaluation and inequality in intimate relationships.

The importance of cognitive schemas (patterns by which a person organizes and interprets experience) for vulnerability to depression has been demonstrated by numerous models, including Aaron Beck's (1987; Beck, Rush, Shaw, & Emery, 1979) extensive work and the general cognitive vulnerability-stress frameworks of Nolen-Hoeksema (1991) and Abramson, Metalsky, and Alloy (1989), updated by Hankin and Abramson (2001). Fundamentally, these models assume that an individual with a cognitive vulnerability, when confronted with a stressful event, interprets the event in a negatively biased way: utilizes dysfunctional thinking (Beck, 1984), makes negative inferences about the event (negative inferential style [Abramson et al., 1989]), or responds with a cognitive style that focuses on current negative situations and feelings (rumination rather than problem solving [Nolen-Hoeksema, 1991]). Based on evidence that cognitive, neurochemical, and affect systems are interrelated, these theories argue that certain cognitive patterns become activated in depression and structure a person's negative interpretations of experience, which also lower the person's mood and motivation.

STS theory differs from diathesis-stress models such as Beck's (1987; Beck et al., 1979) model; Blatt, Quinlan, Chevron, McDonald, and Zuroff's (1982) psychodynamic personality model; Abramson, Metalsky, and Alloy's (1989) pessimistic explanatory style model; and Nolen-Hoeksema's (1991) coping response model in two main respects. First, STS theory does not assume that self-silencing is a stable, permanent trait; instead, the theory construes self-silencing relational schemas as susceptible to the effects of variables within changing social contexts and specific relationships. Second, while diathesis-stress models largely assume a set of vulnerability factors that reside within the individual (Coyne, 1992), in STS theory, the problem is not considered to lie in an individual deficit (such as ruminative coping style [Nolen-Hoeksema, 1991]) or in a personality orientation (dependency-autonomy [Beck, 1987]). Rather, STS theory emphasizes both the importance of cognitive factors and the role of social factors, and regards them as inextricably linked and interactive: Since establishing positive, close connections is a primary motivation throughout life, cognitive schemas about how to make and keep attachments are critical for understanding depression and are affected by social contexts, including gender.

More generally, STS theory can inform the development of a broadly integrative account of depression. Gilbert (2002) described the need for psychology to adopt a "biopsychosocial approach [that] addresses the complexity of interactions between different domains of functioning and argues that it is the interaction of domains that illuminate important processes" (p. 13). In depression, this interaction of domains takes the form of multiple pathways of mutual influence between psychological processes, physiology, and the social world that together determine either emotional wellness or psychological distress. We know, for instance, that during difficult times, sharing one's feelings with others stimulates the release of oxytocin, a hormone that reduces stress (Taylor et al., 2000). Similarly, silencing one's voice may interact 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 (Eisenberger & Lieberman, 2004; Laurent & Powers, 2007; Panksepp, 1998). Because the personal, social, cognitive, and biological are interconnected, and because relational disconnection constitutes a major threat to the self, we consider self-silencing to be a crucial element in precipitating depression.

Men's Self-Silencing: The Puzzle of Gender

The construct of silencing the self was developed through listening to clinically depressed women. It was hypothesized to correlate with gender inequality and was presumed to be more characteristic of women than men. But from the beginning, studies have found that men usually score higher on the STSS than

do women. Also, while self-silencing generally associates with women's depressive symptoms, findings among men are less consistent. Some studies of men have reported significant associations between self-silencing and depression (Duarte & Thompson, 1999; Gratch, Bassett, & Attra, 1995), while others have not (Thompson, 1995; Uebelacker, Courtnage, & Whisman, 2003). We do know, however, that while the STSS subscales replicate among women in the four studies that examine factor structure of the STSS (Cramer & Thoms, 2003; Duarte & Thompson, 1999; Remen, Chambless, & Rodebaugh, 2002; Stevens & Galvin, 1995), for men the subscale structure findings are more complex.

A greater number of studies have examined self-silencing in women than in men, but the foundational ideas that women value relationships more than men and that they quiet themselves out of inequality are challenged by the men's findings. Remembering that STSS items are gender neutral, the findings are intriguing and raise interesting questions: How does men's self-silencing relate to their greater power than women's in society? What aspects of self might they be hiding behind their silence? Are they attributing different meanings to the items on the STSS than do women? Why does men's silence also have negative psychological consequences? Investigations of such questions have included analyses of the different contexts of power out of which self-silencing occurs (Cowan, Bommersbach, & Curtis, 1995) and the different meanings and goals of self-silencing. For example, men's silence may intend to create distance, control interactions in relationships, and protect their autonomy. The precise meaning of men's self-silencing as well as its relation to depression symptoms remains unclear and is addressed in a number of the chapters in this volume (see Chapters 6, 7, 8, and 12 in particular). Taken together, the studies in this book raise a larger question about gender and silence. If gender is reproduced through enactment in social relations, does the differing use of silence by women and men play a key role in this reproduction?

More research, both qualitative and quantitative, needs to be conducted to explore men's experiences of self-silencing. It is evident that self-silencing has negative psychological consequences for both men and women. These consequences, which include an emotional distancing from others and a diminished sense of self-worth, point to the possibility that the construct of self-silencing actually transcends gender. The need for authentic connection to others is a human need, not only a "female" need, so a silencing that leads to social disconnection is detrimental for both women and men. Moreover, while the metaphor of voice has been applied almost exclusively to women's psychology, it is likely equally relevant to men's experiences. If silencing is understood to be a relational process—rather than a personality style or individual trait—then STS theory can help us to situate questions of gender not simply in the realm of either/or dichotomies, but in a more fluid domain that tells us about disempowering contexts. Such an approach can help us to achieve the goal that Cosgrove (2003) set forth in her call for psychological inquiry that is aimed at "researching

gendered experience while simultaneously challenging the ontological status of both gender and experience" (p. 86).

Self-Silencing Across Cultures

Culture has a central place in this book. By the term "culture" we mean "subjective culture," defined as "a cultural group's characteristic way of perceiving its social environment" (Triandis, 1972, p. 3). Culture tells women and men different stories about their place in the world, about who they are, and about who they can and should be. Thus, in our view, gender itself is a culture. We also follow Marsella's (1988, p. 10) definition of psychological culture: "represented internally as values, beliefs, attitudes, cognitive styles, epistemologies, and consciousness patterns." Contributors in this book describe aspects of their particular external culture (Marsella, 1988) in their chapters, that is, its representation in roles and institutions.

Why would the STS theory and the STSS be suitable for use across different cultures, and how might international inquiry using this framework advance our knowledge of women's vulnerability to depression? The STSS has been used in approximately 100 published studies and approximately 18 countries, and has proven to be reliable and meaningful. The construct validity of the STSS has been affirmed by studies demonstrating correlations with hypothesized variables. For example, self-silencing has been found to correlate with "loss of self" (Drew, Heesacker, Frost, & Oelke, 2004), low self-esteem (Page, Stevens, & Galvin, 1996), diminished relationship satisfaction (Thompson, 1995), insecure attachment style (Galvin & Gillespie, 1998; Hart & Thompson, 1996), and childhood abuse (Arata & Lindman, 2002) (see also Jack et al., 2010). Together, the findings from these studies demonstrate the use of STS theory in informing our understanding of psychological processes involved in interpersonal relationships and emotional distress. This book takes these ideas and explores them across a range of cultures and countries to understand what is cultural about depression and how different cultural contexts differentially construct the experience of silencing and depression.

Though the idealized image of a "good woman" varies across cultures, a core premise is that women are unequal to men and yet responsible for the quality of relationships. Women must solve the puzzle of how to achieve intimacy within inequality. The solution presented by preceding generations of unequal marriage (and sexual) contracts (Pateman, 1988) is for women to remain quiet about inequalities in relationships and in society. In order to do so, women must exert tremendous energy against themselves to appear outwardly compliant; they must silence their voices and forgo their desire for an equal say and equal value. They sacrifice the potentialities of genuine intimacy and of self-development by adapting to what the culture sanctions as "valuable" or "normative" for

women. The irony is that these actions, designed to lead to intimacy and safety, lead instead to a loss of self that both increases a woman's vulnerability to depression and decreases the possibilities of intimacy. The particular dynamics surrounding this process of loss of self are likely to differ by culture, as does the nature of the consequences facing women who do not adhere to their socially prescribed roles. Therefore, the lens of STS theory affords researchers the opportunity to engage in inquiry that exposes the dangers of inequality and oppression while at the same time exploring the process through which the social becomes the personal.

The Chapters in This Book

Authors were invited to contribute to this book because their work raised important questions and because their inclusion represented a variety of cultures, disciplines, and methods of inquiry. We looked for researchers both within and outside of the United States who had examined gender and self-silencing in order to highlight the differences in gendered patterns of self-silencing as well as differences in associations with depression. We also sought authors who could provide qualitative as well as quantitative analyses of self-silencing. In addition, we asked well-known experts from the field of psychology and beyond to add their knowledge about social factors in women's depression including human rights abuses, ethical issues related to cultural research on depression, and the use of the biomedical model. Additional experts—Carol Gilligan, Judith Worell, Laura Brown, and Judy Jordan—accepted our invitation to each write a brief introductory piece for sections of the book using their own insights and personal voice.

The chapters in Section 1, "Setting the Stage: Social, Biomedical, and Ethical Issues in Understanding Women's Depression," introduce some of the critical social issues affecting women's depression and psychological distress. This section also addresses key ethical considerations that arise in conducting research on these issues across cultures. Jill Astbury (Australia), in Chapter 2, considers how the language of "risk factors" in depression research masks massive violations of women's human rights globally, and she describes how the language in our models of depression has individualized and decontextualized women's depression. In Chapter 3, Richard Gordon (United States) discusses the impact of the biomedical model on changing conceptualizations of depression in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000), as well as on the rise of antidepressants. Given the importance of research that examines women's depression internationally, the final chapter in Section 1, by Joseph Trimble (United States), María R. Scharrón-del Río (United States), and Guillermo Bernal (Puerto Rico), considers the ethical and methodological issues involved in such research.

Section 2 of this volume, "Self-Silencing and Depression across Cultures," contains chapters that focus on how the social world is reflected in voice and self-silencing across various countries and cultures. Tanja Zoellner and Susanne Hedland (Germany) describe sociocultural expectations that are placed on women and, using compelling examples, how German values regarding women's mothering roles may be reflected in their depression. Linda Smolak (United States) provides a broad sociocultural analysis of gendered responses on the STSS and examines some of the contextual aspects of violence and aggression that affect women's self-silencing. Dana C. Jack (United States) and Usha Subba and Bindu Pokharel (Nepal) examine how self-silencing and depression are affected in gender-specific ways by Nepal's changing social context. Airi Hautamäki (Finland) writes about the generational differences that reflect changing social values in Finland. Krystyna Drat-Ruszczak (Poland) explores the meaning of self-silencing in Polish women in light of Poland's history and images of women. Alisha Ali (United States) demonstrates the different meanings attached to self-silencing among women living in the Caribbean as compared to Caribbean immigrant women living in Canada and the United States. Sofia Neves and Conceição Nogueira (Portugal) provide a window into Portuguese history, changing values, and gender roles that affect women's self-silencing. Offering an overview of a large number of studies conducted in differing social contexts, including India, Anjoo Sikka, Linda (Gratch) Vaden-Goad, and Lisa Waldner (United States) examine the social and interpersonal factors that impinge on women's and men's authentic self-expression. In their chapter, Avi Besser (Israel) and Gordon Flett and Paul Hewitt (Canada) examine gender and personality vulnerabilities associated with depression and self-silencing. Lastly, Guerda Nicolas, Bridget Hirsch, and Clelia Beltrame (United States) provide a rich historical and cultural analysis of women's depression in Haiti, as well as the resistance to oppression mounted by Haitian women.

Section 3, "The Health Effects of Self-Silencing," considers the specific ways that silencing can affect physical health and mental health, as well as some ways of therapeutically addressing these health concerns. In the first chapter of this section, Rosanna DeMarco (United States) describes self-silencing among women in inner-city Boston who have HIV/AIDS, as well as her intervention program that centers on overcoming self-silencing. Mary Sormanti (United States) examines the effects of self-silencing on women who have young children and who are undergoing treatment for cancer, and describes how treatment programs might foster self-care for women who have been diagnosed with cancer. The chapter by Josie Geller, Suja Srikameswaran, and Stephanie Cassin (Canada) provides background on loss of voice and the possible movement toward voice for women with eating disorders. Elaine Eaker and Margaret Kelly-Hayes (United States) provide evidence from the large, prospective Framingham Offspring Study showing that women who self-silenced during marital arguments were four times more likely to die over the subsequent

10 years than were women who did not self-silence. Maria Medved (Canada) examines how women who are in support groups after myocardial heart infarction are silenced by approaches to treatment that are derived solely from men's experiences with heart disease. She presents evidence of how treatment can address self-silencing in order to facilitate women's positive coping to help them return to health. Jane Ussher and Janette Perz (Australia) analyze the purported distress associated with premenstrual symptoms and propose that such "symptoms" are in fact women's authentic expressions of the anger and dissatisfaction that they silence during the other 3 weeks of their monthly cycle. Natasha Mauthner (Scotland) presents the work of herself and others to demonstrate that women experiencing postpartum depression feel compelled to silence aspects of themselves in order to fulfill cultural expectations of motherhood. Stephanie Woods (United States) describes the associations between women's experiences of self-silencing, intimate partner violence, and physical and mental health symptoms, as well as the implications these associations have for providing responsive health care for abused women. The last chapter of this volume is a commentary and critique by Janet Stoppard with suggestions for further research.

These chapters provide broad evidence of the importance of personal agency in the lives of women experiencing physical and mental health problems. As these authors and other contributors to this book demonstrate, understanding depression and other conditions as being strongly influenced by self-silencing not only helps us to conceptualize and contextualize psychological distress but also allows us to envision the discovery and recovery of voice as a transformative step toward health and wellness.

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The Social Causes of Women's Depression: A Question of Rights Violated?

Jill Astbury

> "The violation of any right has measurable impacts on physical, mental and social well-being; yet these health effects still remain, in large part, to be discovered and documented. Yet gradually the connection is being established."
>
> Mann, 1999, p. 445

From the 1978 publication of *The Social Origins of Depression: A Study of Psychiatric Disorders in Women* by the British researchers George Brown and Tirril Harris, a large body of research literature has been amassed on the social factors linked to the development of depression in women. Multicountry studies reporting wide intercountry variation in rates of depression support the findings of national surveys that specific cultural arrangements, gender roles, life events, and socioeconomic and occupational factors make a significant contribution to the initiation and maintenance of depressive disorders (Brown, 1998; Patten, 2003; Ustun & Sartorius, 1995; World Health Organization [WHO], International Consortium of Psychiatric Epidemiology [ICPE], 2000).

While the social factors identified to date assist in explaining women's significantly higher rates of depression compared with men's (Brown, 1998; Brown & Harris, 1978; Brown, Harris, & Hepworth, 1995; Kessler, 2003), very little previous research on social factors has focused explicitly on human rights and framed human rights violations as a crucial social determinant of the marked gender disparity in rates of depression and other psychological disorders.

It will be argued here that the adoption of a human rights analytic framework would expand our current understanding of the social causes of depression in women and, at the same time, provide new perspectives on research, mental

health promotion, and clinical treatment. A rights-based analytic approach also offers an alternative means to appraise and interpret current risk factor–based research into women's depression.

The Right to Health

The right to health is a fundamental human right and one that is explicitly identified in a number of human rights instruments. These include the Universal Declaration of Human Rights (1948), the International Convention on the Elimination of All Forms of Racial Discrimination (1965), the International Covenant on Economic, Social, and Cultural Rights (1976), the Convention on the Elimination of All Forms of Discrimination against Women (1979), and the Declaration on the Elimination of Violence against Women (1993).

Depression in Women: A Priority Public Health Issue

Depressive disorders, including major depression consisting of one or more major depressive episodes and dysthymia, constitute the most common psychological disorders experienced by women. The WHO has recognized that depression is a priority public health concern (WHO, 2001). The Global Burden of Disease (BOD) study estimates underpin the prediction that depression will be the second leading cause of disease burden in developing and developed countries by 2020. The importance of depression as a mental health concern is underlined by the fact that it accounts for the largest proportion of the burden of all mental and neurological disorders (Murray & Lopez, 1997).

The gender disparity in rates of depression, where women predominate in an approximately 2:1 ratio over men, is one of the most robust findings of psychiatric epidemiology (Astbury, 2001; Bebbington et al., 2003; Kessler, 2003, Kessler et al., 1994; Piccinelli & Homen, 1997; Weissman & Klerman, 1977). This disparity indicates an urgent need for gender-specific strategies to stem the rising tide of global disability caused by depression that is predicted for 2020.

Gendered Risk

The 1998 World Health Report stated unequivocally that "no society treats its women as well as it treats its men." Eight years after this report, the 2006 World Development Indicators revealed that:

> Unequal treatment of women - by the state, in the market and by their community and family - puts them at a disadvantage throughout their lives and stifles the development prospects of their societies. (World Bank, 2006)

Somehow this large and, in many places, continuing divide in the social treatment of women compared with men has remained something of a blind spot in the scientific imagination of psychiatric epidemiologists. Yet female gender clearly serves as a locus for many kinds of social ill treatment. According to a report prepared by Professor Fareda Banda for the United Nations human rights commissioner, Louise Arbour, women make up more than 70% of the world's poor and two-thirds of its illiterate, and own a tiny 1% of the world's titled land. For women in 53 nations, rape in marriage has not been criminalized (BBC News, 2008).

Women experience high rates of gender-based violence across the life course, beginning with selective female feticide, infanticide, childhood sexual abuse including forced child marriage, intimate partner violence, and adult sexual violence (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). According to the International Labour Office (ILO) (2005) in its report on forced labor, women and girls predominate among those trafficked for forced economic exploitation (56% women and girls compared with 44% men and boys) and are overwhelmingly at risk of being trafficking for forced commercial sexual exploitation (98% compared with 2%). The ILO (2005) estimates that 1,390,000 women and girls have been trafficked across national borders for forced commercial sexual exploitation. In war and conflict situations, sexual violence against women is used as a military tactic and has been recognized by the United Nations as organized and systematic. In June 2008, the UN Security Council approved a resolution acknowledging that sexual violence profoundly affects not only the health and safety of women but also the economic and social stability of their nations (Farley, 2008).

It is difficult to ignore the possibility that gender disparities in the rates of many psychological disorders could issue from and reliably reflect these various forms of socially condoned ill treatment.

Women predominate not only in diagnoses of depression and also in many of the disorders that commonly accompany depression, including anxiety disorders such as posttraumatic stress disorder (PTSD), panic disorder, borderline personality disorder, certain phobias, and somatization disorder. Women also predominate among the population of people with high levels of psychiatric comorbidity (three or more comorbid disorders) who suffer the highest levels of impairment (Kessler et al., 1994). The high prevalence and severe impact of depression and related disorders on women's sense of themselves, their quality of life, their relationships, and their social and occupational functioning demonstrate why depression in women deserves particular attention from researchers, policymakers, and clinicians.

The very existence of the large gender disparity in rates of depression might, in itself, be taken as prima facie evidence that women's fundamental human right to mental health was routinely violated. This gender difference first emerges in

puberty (Kessler, 2003; Wade, Cairney, & Pevalin, 2002) and declines from midlife onward, although evidence on the age when the sex difference ceases to be important varies from one study and one country to another (Akhtar-Danesh & Landeen, 2007; Andrews, Hall, Teeson, & Henderson, 1999; Bebbington et al., 2003; Kessler, Foster, Webster, & House, 1992).

Although national surveys indicate that women experience significantly higher rates of depression than men during their reproductive years, this cannot be taken as unequivocal evidence of biological causation of depression in women. During these same years, a number of coexisting but nonbiological independent risk factors for depression are highly prevalent. These include the triple burden of paid work, unpaid household work, and heavy caring responsibilities and high rates of intimate partner violence and sexual violence (Astbury & Cabral, 2000; Vos et al., 2006).

Research to date on war and conflict situations indicates that there is a graded relationship between the degree of trauma experienced by victims of war and the extent and severity of their subsequent psychological symptoms. A review of research studies from Afghanistan, the Balkans, Cambodia, Chechnya, Iraq, Israel, Lebanon, Palestine, Rwanda, Sri Lanka, Somalia, and Uganda concludes that women have an increased vulnerability to the psychological consequences of war such as PTSD, anxiety, and depression (Srinivasa-Murthy & Lakshminarayana, 2006). The deliberate targeting of women and girls as objects of sexual violence during war and conflict will be discussed later, but such violence represents a common and severe source of the kind of trauma linked with common mental disorders (Srinivasa-Murthy & Lakshminarayana, 2006).

Language: Risks versus Rights

The standard public health approach to reducing the level of a negative health condition in a given population, and one that underpins BOD estimates, begins with the identification of all risk factors relevant to that condition. Ezzati, Lopez, Rodgers, Vander Hoorn, and Murray (2002) argue that it is only through reliable and comparable analysis of risks to health that effective efforts to prevent disease and injury can be developed.

The term "risk factor" is largely a product of epidemiological research. It arose out of the recognition that for many serious health conditions such as cardiovascular disease, no single cause could be identified, let alone eliminated. Instead, multiple factors, dubbed "risk factors," were found to be associated with a statistically significant increase in the risk, if not the certainty, of developing such a disease.

Many risk factors for poor health, including poor mental health, are inextricably linked with or embedded in the position a person or groups of people occupy in the social hierarchy, as evidenced by the very large research literature

that has emerged since the 1980s on the social gradient in health (Stansfeld, Head, Fuhrer, Wardle, & Cattell, 2003; Stansfeld, Head, & Marmot, 1998; Townsend & Davidson, 1982; Wilkinson, 1997). This literature illustrates that those who occupy a lower position in the social hierarchy and experience protracted socioeconomic adversity have significantly higher rates of many adverse health outcomes, including depression, than those who occupy higher social positions in that hierarchy. Significant differences in health outcomes between groups occur at all points on the gradient, not just in comparisons between the lowest versus the highest points, and indicate that poverty alone is insufficient to account for them.

Through its use of the scientific language of "risk factors" or "vulnerability factors" that are "correlated" with "exposure" to "adverse" or "negative life events or experiences," existing research into the social factors that predict depression in women has unwittingly deflected our attention from the possibility that such "risk" and "vulnerability" factors might stand for something else. In particular, previously identified social risk factors for depression in women might more accurately be conceptualized as proxy variables for a range of rights violations. Moreover, if rights violations are occurring but are not being named as such because the biomedical, epidemiological terminology of "risk" serves to conceal rather than elucidate them, then it can be argued that such language is likely to be, as Mann (1999) puts it, "inapt and inept" in identifying the important forms of human suffering and injuries to human dignity that are, in fact, taking place. The inappropriateness of using the standard term "disorder" in conjunction with the suffering associated with human rights violations, as in "dignity disorder," "humiliation disorder," or "unfairness disorder," supports this assertion.

The language used by researchers and mental health professionals stakes a claim to the ownership of the intellectual or experiential territory being explored. For example, the language of psychiatry can be used to assert that much mental suffering is appropriately conceptualized as psychiatric disorder, whose causes derive primarily from biochemical alterations or malfunctioning in the brain itself. It follows from this that biochemical means will be needed to rectify the psychiatric disorder in question and that only those mental health professionals with the credentials to use these means ought to be involved in this endeavor. A model of mental illness that stresses biological causation may explain why much psychiatric discussion of human rights tends to focus on the stigma and discrimination that those with psychiatric "disorders" encounter from the wider community (Arboleda-Florez, 2001). The otherwise exemplary WHO (2001) initiative to combat stigma and discrimination, "Stop exclusion, Dare to care," also carries the implication that the primary way in which human rights violations matter in mental illness resides in the discriminatory and stigmatizing attitudes of the wider community toward those who are mentally ill. In other words, while human rights violations are certainly considered as an

important consequence for those living with an existing mental illness, they are not typically entertained as a likely cause of such illness.

By contrast, a focus on human rights violations centralizes their possible role in the development of certain forms of poor mental health, such as depression. The language of rights steps beyond the terminology of scientific, neutral, decontextualized "risks" into a more political sphere. Within a rights framework, countries that are signatories to various human rights conventions that include the right to health become accountable for the health inequalities that their systems of organization and privilege, generate and sustain.

Dignity versus Humiliation

The most basic human right and one that serves as a precondition for many others is the right to dignity. The first article of the 1948 Universal Declaration of Human Rights (UDHR) asserts that:

> All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

It is ironic that even while proclaiming equality, dignity, and rights for everyone, the declaration appeals to a spirit of brotherhood, oblivious to the possibility that this reflects gender bias. Several of the articles in the declaration also refer to "himself and his family" and "his rights and freedoms," and while it is true that this reflects language usage at the time the declaration was adopted and proclaimed, it is also true that the language continues to reflect gender inequalities in the enjoyment of rights today. In discussing the fact that many people live in "dignity-impugning" environments, Mann (1999) argues that an exploration of the meanings of dignity and the forms of its violation may help to uncover "a new universe of human suffering" that is detrimental to physical, mental, and social well-being.

Existing research on risk factors for depression has not been informed explicitly by a human rights approach; therefore, much of the psychological suffering deriving from human rights violations is unlikely to have been named or documented, let alone measured. The naming of different forms of human suffering logically precedes the possibility of being able to count or quantify them: "Child abuse did not exist in meaningful societal terms until it was named and then measured; nor did domestic violence" (Mann, 1999, p. 449).

Quite simply, researchers have not been moved to measure the mental health impacts for women (or men either) of the violation of their rights. These include, to name but a few from the UDHR, the right to:

- Liberty and security of person (Article 3)
- Not to be held in slavery or servitude (Article 4)

- Not to be subjected to torture or to cruel, inhuman, or degrading treatment of punishment (Article 5)
- Equality before the law . . . without any discrimination. . . (and) equal protection of the law (Article 7)
- Freedom of movement (Article 13)
- Equal rights as to marriage, during marriage, and at its dissolution (Article 16)
- Just and favorable conditions of work including equal pay for equal work (Article 23)
- A standard of living adequate for health and well-being (Article 25)

Despite the lack of explicit rights-based research regarding the development of depression in women, a number of studies do provide findings that are germane to the appraisal of the relationship between damage to dignity and/or rights violations and the subsequent experience of depression.

To support the asserted relationship between women's rights violations and the gender disparity in depression, three main types of research findings will be considered. First, I will provide a brief overview of the psychological impact of gender-based violence. The multiple forms of gender-based violence violate many of women's most basic human rights including their right to dignity, liberty, and security of person; their right to health, given the multiple negative mental health outcomes of such violence; and, in a significant number of cases, their right to life.

Second, I will focus on evidence relating to the psychological consequences of experiences or situations involving humiliation that attack human dignity. According to the Oxford dictionary, one of the meanings of "humiliate" is to injure the dignity or self-respect of a person, and while "indignity" is the antonym of "dignity," humiliation is a very closely related concept. Maintaining dignity relies to a great extent on being able to exert some control over one's person, behavior, and life. Being deprived of autonomy and control necessarily impugns dignity.

Third, I will examine the mental health impacts of unfair treatment within the workplace, focusing on interpersonal mistreatment. Emerging research in this area provides an additional line of evidence that links dignity-impugning environments and experiences with psychologically harmful outcomes and illustrates how exposure to such environments and experiences is differentially affected by gender and a subordinate position in the organizational hierarchy.

Gender-Based Violence

In April 2003, the Human Rights Commission of the UN passed a resolution expressing concern about the magnitude of the findings of the World Report on Violence and Health (Krug et al., 2002). This report noted that the lifetime prevalence of physical intimate violence reported by women, based on 48 population-based studies from around the world, ranged from 10% to 69%.

The commission acknowledged that violence is an obstacle to the full realization of the right to the highest attainable standard of health and to the enjoyment of other human rights.

Nowhere is the link between human rights violations and poor mental health for women more apparent than in the voluminous literature on the negative mental health consequences of gender-based violence (GBV). Being born female carries with it heightened "vulnerability" or "risk" of experiencing violence from an intimate or someone known to the victim, with the highest prevalence of such violence occurring in younger women.

The WHO multicountry study on women's health and domestic violence is a particularly valuable source of data (Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008). It was carried out in 15 sites and 10 countries (Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania) between 2000 and 2003 and utilized a sample of more than 24,000 women aged between 15 and 49 years, Using standardized population-based household surveys, this study found that the lifetime prevalence of physical or sexual partner violence, or both, varied from 15% to 71% (Garcia-Moreno et al., 2006). For all settings combined, the destructive mental health impact of domestic violence is revealed very clearly. Women who reported partner violence at least once in their life compared with their nonviolated peers had an almost 3-fold increase in the odds of reporting emotional distress and suicidal thoughts (odds ratio [OR] 2.9, 95% confidence interval [CI] 2.7–3.2) and almost 4-fold increased odds of suicidal attempts (OR 3.8, 95% CI 3.3–4.5).

A large-scale U.S. study on the long-term consequences of childhood sexual abuse illustrates the compounding health effects of gender-based violence over the life course. Dube and colleagues (2005) reported that women who were sexually abused as children, compared with their nonabused counterparts, were more than twice as likely to have attempted suicide in adult life, were at a 40% increased chance of marrying an alcoholic, and had a similar increased risk of reporting current problems with their marriage.

Gender-based violence, including child sexual abuse, sexual violence in later life, and intimate partner violence, is associated with a significantly elevated risk of a range of negative mental health outcomes (Resnick, Acierno & Kilpatrick, 1997). These outcomes encompass increased rates of depression including postnatal depression and dysthymia but also anxiety, suicidality, PTSD, panic disorder and certain phobias, substance use disorder, somatization and dissociative disorder, and high levels of psychiatric comorbidity (Astbury & Cabral, 2000; Campbell, 2002; Hegarty, Gunn, Chondros, & Small, 2004). It is unlikely to be a coincidence that most of these disorders are characterized by a significant gender disparity in rates.

Women abused in both childhood and adulthood have even higher rates of many of these disorders, suggesting a graded relationship between the number of exposures to violence and the extent and severity of the negative mental health outcomes (Astbury, 1996; Chapman et al., 2004).

The deliberate exercise of coercive control by perpetrators over their female victims takes the form of physical, emotional, and sexual violence and ensures victims are socially isolated and cut off from potential avenues for psychosocial support. Men who are more controlling were reported to be more likely to be violent against their partners in the WHO multi-country study (Garcia-Moreno et al., 2006). Unlike the workplace bully who has to contend with some limitations on the scope of the bullying in time and place, the bully at home has greater scope for exercising power and control. In epidemiological terms, the "dose" and the "duration" during which the violence can be delivered are both increased.

In an Australian BOD study (Vos et al., 2006), intimate partner violence (IPV), including sexual violence, was investigated as a health "risk" factor and compared with a range of previously well-investigated health risk factors. This study found that IPV constituted a greater risk for ill-health among women aged younger than 45 years than all seven of the other major health risk factors examined. These other risk factors were the ones typically included in contemporary BOD estimates, such as high body weight; high cholesterol; high blood pressure; harmful alcohol, illicit drug, and tobacco use; and physical inactivity. IPV was associated with more than twice the risk to health as the next most important factor, illicit drug use, that contributed to less than 4% of the BOD. The largest contribution to the burden of disease associated with IPV was poor mental health. Depression, anxiety, and suicide together contributed to 73% of the total disease burden associated with IPV. Harmful health-related behaviors (tobacco, alcohol, and illicit drug use) that often co-occur with poor mental health accounted for another 22% of the disease burden attributable to IPV.

The psychological damage inextricably linked to the perpetration of gender-based violence against girls and women constitutes a critical injury to their dignity and self-respect. As noted elsewhere, violence against women, whether by their intimate partners or men not known to them, is the most prevalent and most emblematic gender-based cause of depression in women (Astbury & Cabral, 2000). Such violence encapsulates humiliation, subordination, grossly unfair treatment, and blocked escape or entrapment.

Constant denigration, subordination, and humiliation inevitably enforce a sense of inferiority, shame, and reduced self-respect and illustrate why the victim might lose her sense of self and succumb to the perpetrator's views of her worth. This damage to dignity and self is evident in the comment made by Ana Christina, a participant in Ellsberg's (1997) research in Nicaragua:

> He used to tell me, 'you're an animal, an idiot, you are worthless.' That made me feel even more stupid. I couldn't raise my head. I think I still have scars from this, and I have always been insecure. ... I would think, could it be that I really am stupid? I accepted it, because after a point ... he had destroyed me by blows and psychologically. (p. 8)

One of the U.S. participants in Jack's (1991) study on women and depression speaks eloquently of the self-silencing effects of living a life of fear with an intimate partner who violently enacts his beliefs regarding male privilege and superiority, while simultaneously assigning all responsibility for that violence to his female victim:

> 'No goddamn woman is going to tell me what to do and control my life' and 'I'm going to do what I have to do here. You're going to make me have to tune you up. You want me to stomp the shit out of you.' Reactions like that, and it makes you back off. And over a period of time, like two or three years, you become accustomed to not voicing anything. (Jack, 1991, pp. 35–36)

The coercive control exercised by a violent intimate partner militates against victims being able to access social support. By contrast, if violence is disclosed to a trusted friend, relative, or health care professional, the possibilities for psychosocial support immediately increase. One study (Coker, Smith, et al., 2002), which examined the practice of screening for IPV in family practice clinics in South Carolina, reported that among women experiencing IPV, those with higher social support scores had significantly reduced risks of having poor perceived mental and physical health. The risks of anxiety for these women compared with those with low levels of social support were significantly reduced (adjusted relative risk [aRR] 0.3, 95% CI 0.2–0,4) as were their risks for depression (aRR 0.6, 95% CI 0.5–0.8), PTSD symptoms (aRR 0.5, 95% CI 0.4–0.8), and suicide attempts (aRR 0.6, 95% CI 0.4–0.9) (Coker, Davis, et al., 2002).

Besides psychosocial support, a sense of mastery, or feelings of being in control of forces that affect one's life, appears to afford protection to the mental health of pregnant women. Rodriguez and colleagues (2008), in their study of pregnant Latina women in Los Angeles, reported that the risk for depression was reduced by almost 30% in women with a greater sense of mastery. Conversely, risk increased significantly for both depression and PTSD for women with a history of trauma and IPV. Restoring feelings of being in control of the determinants of their lives is a critical task for survivors of all forms of gender-based violence. The mental health importance of being able to exercise control has also been confirmed in numerous studies of health in the workplace (Matthews & Power, 2002; Mausner-Dorsch & Eaton, 2002; Stansfeld, Head, Fuhrer, et al., 2003).

These findings illustrate that mental health interventions cannot be confined to the diagnosis and clinical treatment of psychological disorders. Such an approach fails to address the multiple instances of unfair and violent treatment that significantly predict depression and associated mental health conditions such as PTSD in women. By placing these matters outside the parameters of clinical concern, a major opportunity is missed to reduce preventable causes of depression (WHO, ICPE, 2000).

The strength of the evidence on the mental health effects of GBV mandates that competent health practice must ascertain not only whether a woman is