

Self-Silencing and Marital Adjustment in Women With and Without Depression

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This study compared women with and without depression on self-silencing, marital adjustment, and depression. The study also investigated the predictive role of self-silencing and marital adjustment for depression. Two samples were recruited from various Psychiatric units and General Medical wards of different hospitals of Lahore, Pakistan including 80 women diagnosed with depression ($M_{age} = 37.16$ years, $SD = 8.5$) and 80 women without depression ($M_{age} = 36.64$ years, $SD = 7.7$). Using Urdu versions of Silencing the Self Scale (Jack & Dill, 1991), Dyadic Adjustment Scale (Spanier, 1976) and DSM-5 Cross-cutting Measure for Depression and Severity Checklist for Depression (American Psychological Association, 2013), the results revealed that self-silencing was significantly higher in women with depression than the other group while marital adjustment was better in women without depression than the women with depression. Depression was positively correlated with self-silencing and negatively correlated with marital adjustment for the sample of women with depression. Regression analysis revealed Externalized Self-Perception subscale of Silencing the Self Scale appeared to be a positive predictor while Dyadic Satisfaction and Dyadic Cohesion subscales of Dyadic Adjustment were negative predictors of depression. The study implied that psychologists especially couple/marriage counselors may need to focus on the communication patterns of spouses for decreased chances of depression.

Keywords. Self-silencing, depression, marital adjustment, externalized self-perception, dyadic cohesion

Psychological disorders, especially depression has peaked in the last decade profoundly in Asian countries with an estimate of almost 86 million individuals (World Health Organization, 2017). Four percent individuals across the world have become a victim of depressive episode with a male to female ratio of 3:4.5 (Ritchie &

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Roser, 2018). Recent studies have increased focus on communication patterns between families, parent-child relationships, spouses as means towards alleviating depressive symptoms (Haverkamp, 2017) and improving well-being. With Pakistan's heightened ratio of depression in women (Ahmed, Enam, Iqbal, Murtaza, & Bashir, 2016), a collectivistic and patriarchal societal setting (Ahmad & Anwar, 2018; Cheema, Khan, Mohmand, & Liaqat, 2019) and major emphasis on marital relationships, the current study has been designed to study the role of self-silencing and quality of marital adjustment in depression among women experiencing depression and women without depression.

Depression

Depression, these days, is used as an umbrella term covering a wide range of low mood states (Goldberg, Eastwood, LaGuardia, & Danckert, 2011). Clinical depression or Major Depressive disorder (MDD), on the other hand, is characterized by depressed mood throughout the day and a decreased interest in pleasurable daily life activities (anhedonia). These two symptoms are supposed to cause clinically significant impairment in an individual's educational, social and occupational functioning to warrant a formal diagnosis (American Psychological Association [APA], 2013). In addition, MDD can also be detected by a 5% increase/decrease in total body weight, insomnia/hypersomnia, feeling fatigued, developing a sense of worthlessness or hopelessness, and suicidal ideation. The Diagnostic Statistical Manual 5 (DSM-5, APA, 2013) also claims that the prevalence of depression is 1.5 to 3 times higher in women as compared to men. Most causal factors and theories explaining depression are proposed regardless of the gender but high prevalence in women indicates that some characteristics might make women more vulnerable towards developing it (APA, 2013). According to the World Health Organization's report (2017) depression is the leading mental health disorder in the global population. It is estimated to be in 4.4% of the population across the world. Moreover, it is more common in women (5.1%) than in men (3.6%). Associated with depressive symptoms, is the self-silencing behavior coined by Jack and Dill (1991) after her extensive work on communication patterns of women displaying symptoms of depression.

Self-silencing

Self-silencing is a practice of willingly withholding the expression of one's emotions, opinions, strengths, and abilities. This is

carried out by an individual under the pressure of maintaining relationships and fulfilling responsibilities by going beyond of what is necessary for his/her own choice (Jack & Dill, 1991). Self-silencing was introduced after the extensive study of depression, low self-esteem, and negative self-evaluation in women. The attitude of women in relationships, their inner feelings, strengths, weaknesses, fears, vocalization, identity, and moral development were kept in focus in order to extensively explore the phenomenon (Miller & Rogers, 2007). According to the findings a woman tries to be a 'good wife' or a 'good mother' by emphasizing on qualities such as sacrifice, selflessness, subordination, suppression of negative feelings, repression of anger, and reduction of self-assertion (Jack & Dill, 1991). These qualities are then passed on to next generations as a custom or gender role. The phenomenon was explained by Jack (1991) in her model of goodness which explained how women tend to fulfill their gender role by holding themselves back. They also linked self-silencing to the connection between actual self and the ideal self. The ideal self was further away from its actual self based on its dependence on social acceptability and approval. The inability of expressing own desires leads to an inferior sense of self. The theory describes both, suppression and repression of desires, feelings, wants, opinions, and actions to maintain a congenial and working relationship by placing the spouse's needs at a higher hierarchical level than his/her own. While self-silencing has been studied to be a phenomenon exhibited by both men and women, its theory was primarily postulated for women who wanted a harmonious and psychologically sound relationship. In order to achieve such a bond, women try their best to avoid contradictions, conflict of thought and interest to the extent of silencing their voice. The disconnection from one's physical and psychological needs can then lead to poor self-esteem, feelings of loneliness, anger, and hatred towards the partner, sense of neglect, self-confinement, and dissatisfaction from the spouse. The theory also explained this phenomenon through the terms of an 'ideal self' or a 'good woman'. It is an image created by the societal expectations, norms, customs, values and beliefs molding women into a selfless, caring, sacrificing, subordinate and gentle body. Repeated sacrifices, repression of voices and subordination created a conflict between the self and the societal standards generating confusion, anger, frustration, irritability and a sense of failure in the women (Jack & Dill, 1991).

Gender-based studies predict greater prognosis, higher willingness towards treatment for HIV and better mental health when self-silencing was low in women (Brody et al., 2014a, 2014b; Jack &

Ali, 2010; Ussher & Perz, 2010). Comparison studies tend to show higher vulnerability and association of self-silencing with depression in females as compared to male population. These variables are further mediated by self-concealment and self-esteem (Cramer, Gallant, & Langlois, 2005). Cross-cultural studies and women from diverse ethnic backgrounds have been repeatedly studied to show significant markers of depression as a result of silenced attitudes, beliefs, and emotions (Grant, Jack, Fritzpatrick, & Ernst, 2011; Ussher & Perz, 2010).

Communication gap and hindrance to express one's views and intentions have not only been seen to jeopardize interpersonal relations rather have disrupted individual functioning as well. An inhibited sense of self-exposure, a constant drive for sacrifice and a loss of personal voice decline the individual's ability to truly be or become what he/she wants (Harper & Welsh, 2007). Intellectual, physical (Eaker & Kelly-Hayes, 2010); psychological (Hambrook et al., 2011); familial and academic (London, Downey, Romero-Canyas, Rattan, & Tyson, 2012) functioning have all been studied to be disturbed due to self-silencing. Even in college students, this specific trait lessens the motivation to strive for success or avoid failure, increased distress and dysfunctional behavior (Hurst & Beesley, 2013; Shouse & Nilsson, 2011).

The act of self-silencing is manifested in various ways according to its theory including externalized self-perception, divided self, self-sacrifice, and silencing the self. Judging oneself based on externally set norms and standard is referred as *externalized self-perception* which has been seen to contribute more towards mental breakdowns and low self-esteem (Woodward, McIlwain, & Mond, 2019). The *divided self* is a conflicting internal and external personality. When one appears to be compliant or submissive on the outside but is filled with rage, anger or hostility within him, he/she is viewed to have inner/outer conflict, hence, a divided self. This identity confusion and conflict can thus, induce stress, anxiety, and depression symptoms in an individual (Hirsh & Kang, 2016). While sacrifice in relationships is important, *self-sacrifice* is a contradictory construct which emphasizes to put other's needs, emotions, and views before one's own. The phenomenon inhibits the individual to express his/her perspectives or he/she refrains from putting any demands forward. Sacrifice of personal needs is thus considered a basic process which if not practiced will disrupt relational attachments (Szymanski, Ikizler, & Dunn, 2016). Finally, the last sub-domain that is *silencing the self* is the inability to express what the individual needs, feels, wants or likes. It is the inhibition of self-expression about any conflict that may cause

relational disruption or discomfort for one's partner (Kurtiş, 2010).

South Asian countries have a collectivistic culture with high pressure to conform with societal standards and cultural values (Kim, Li, & Ng, 2005). While these values enhance interdependence, trust, reliability, and a sense of belongingness, it pressurizes the individual to inhibit from expressing ideas or actions that may reflect badly upon the group. Thus, the individuals, especially women make their duty to defend the family's honor even if it is to sacrifice one's needs, suppress voices or show incongruent emotions (Tsong & Smart, 2015). Even in Pakistani women, there is no exception. Women tend to experience violence but there are few who report the disgrace. They are determined to save their husband's integrity by silencing their voices and portraying themselves as a 'good woman' or a 'good wife'.

Marital Adjustment

Marriage being the basic institution of society comprises of days, months and years of mutually handling situations through concern, love, affection, understanding, and repeated effort (Rizvi, 2014; Sharma, Pandit, Pathak, & Sharma, 2013). It has its perks such as the feelings of connectedness, mutuality, intimacy, and trust but may also have its downs where the partners tend to grow apart, develop disputes, or feel caged. Marital adjustment is the mutual understanding and a shared feeling of joy, contentment, pleasure, and approval between a husband and wife regarding their marriage which increases with the age of marriage (Arshad, Mohsin, & Mahmood, 2014). It is the degree to which married partners accommodate each other in the established relationship (Kendrick & Drentea, 2016). It has been found that marital adjustment is not a temporary state rather a continuous process in which no matter how much two people know each other, they may change after sometime, and then the degree to which both sides accept each other besides the change is considered as marital adjustment. It is based upon *dyadic consensus* which is the level of agreeableness between partners. It also encompasses dyadic satisfaction and *dyadic cohesion* which is the physical and psychological satisfaction between spouses and also the shared activities that strengthen their marital bond (Spanier, 1976).

Maturity, mutual understanding, social recreation, religion, children, in laws, economic conditions, sexual relationships, level of communication, trust, companionship, agreement, contentment, stability, apprehension, respect, and care are some factors that contribute in the building up of marital adjustment (Muraru & Turliuc, 2013). The impact of marital adjustment is not only on the physical

health of the spouses but it also impacts the mental health of the spouses. Partners who share feelings of happiness and contentment tend to have long and more stable marriages as compared to disputed marriages ending in divorce. Poorly adjusted marriages also make spouses vulnerable towards stress, anxiety, and depressive symptoms thus, lowering their psychological well-being (Humbad, Donnellan, Iacono, & Burt, 2010; Kamp-Dush, Taylor, & Kroeger, 2008; Kouros & Cummings, 2011).

Communication in marriage is one of the key aspects in gluing together both partners. Interaction patterns, communication styles, and attachment styles greatly affect the quality and stability of marriage (Knoke, Burau, & Roehrle, 2010). Furthering the work of Jack and Dill (1991) on self-silencing, Whiffen, Foot, and Thompson, 2007 (2007) studied the relationship of marital conflict, self-silencing, and depression. According to them, women have a stronger desire to maintain close relationships and thus, have a greater ability to shut down their sense of self. Their intentions to maintain relational harmony is achieved through self-sacrifice which increases their risk towards depression. Not only does it affect their mental health but also creates dissonance with their own feelings, resulting in self-alienation. The disrupted self and psychological distress in spouses deteriorates the relationship even more and can even lead to domestic violence (Chisale, 2018).

In order to test the previous literature in Pakistani context, the present study was conducted to assess the relationship between depression, self-silencing, and marital adjustment. The study focused on the women population specifically as they constitute almost half of the population of Pakistan but are present in a male-dominating society, where they are being neglected in vast areas of life (Ashraf, Abrar-ul-Haq, & Ashraf, 2017). One of the most neglected forums is the household environment where housewives are given least importance. Despite their endless work, care and sacrifices, they are taken lightly and as a consequence their basic needs and requirements remain unaddressed (Zainab, Jadoon, & Nawaz, 2017). The growing increase of depression in Pakistan's population and the high cultural standards needed to be met by women suggested urgency to develop an understanding of their needs. The general home atmosphere of majority houses comes with a dominant male partner and a submissive wife. The patriarchy inside the houses also made it important to tap self-silencing behavior with marital adjustment especially with women who are housewives (Hadi, 2017). This study focuses on women who specifically remain at home and are not indulged in any kind of work activity outside the house as they are not able to

channelize their inhibitions or converse about them. This helped to maintain focus on the silencing relationship between spouses rather than other confounding variable, such as work stress and silencing behavior at work. Initial adjustment in marriage was also ruled out as spouses take about 2 to 3 years to get adjusted with each other after their marriage (Newby & Carter, 2010), hence, the inclusion criteria was used accordingly. Even though self-silencing has been linked to depression in the prior literature, there was dire need to study self-silencing in married couples, especially in the context of a collectivistic and patriarchal society. The study also undertakes the sample of non-depressed women to compare and confirm the differences of self-silencing and marital adjustment in both groups. While finding the link between variable was necessary it was also appropriate to study the logistics behind a happy marriage when communication and psychological health was concerned.

Hypotheses

Review of the literature provides with these hypotheses for the current study:

1. Women with depression will have higher scores of self-silencing as compared to women without depression.
2. Marital adjustment will be higher in women without depression than women with depression.
3. Depression will have significantly positive correlation with self-silencing and significantly negative correlation with marital adjustment.
4. Self-silencing will positively predict depression.
5. Marital adjustment will be a negative predictor of depression.

Method

Purposive sampling was used to recruit 160 female participants for the current study. The sample comprised of 2 groups; group 1 included 80 women with depression with age ranging from 25 to 50 years ($M = 37.16$, $SD = 8.5$) while group 2 comprised of 80 women without depression with age ranging from 25 to 50 years ($M = 36.64$, $SD = 7.7$). The entire sample was selected from psychiatric and general wards of public (Mayo Hospital, Services Hospital) and private (Shalamar Hospital and Fatima Memorial Hospital) hospitals of Lahore. All participants were screened to be married for at least two years. Working women were excluded from the study. Detailed

descriptions of sample characteristics are given in Table 1.

Table 1
Demographic Characteristics of Women with Depression and Women without Depression (N=160)

Demographic Variables	Women with Depression (n = 80)		Women without Depression (n = 80)	
	f	%	f	%
Family Status				
Nuclear	44	55	60	75
Joint	36	45	20	25
Monthly Family Income (PKR)				
Less than 5000	6	7.5	0	0
5,001-10,000	6	7.5	5	6.3
10,001-20,000	12	15	3	3.8
20,001-30,000	12	15	6	7.5
30,001-40,000	9	11.3	14	17.5
40,001-50,000	10	12.5	12	15.0
More than 50,000	25	31.3	40	50.0
Education				
Primary	6	7.5	4	5.0
Middle	9	11.3	0	0
Matriculation	18	22.5	11	13.8
F.A./F.Sc.	17	21.3	15	18.8
B.A./B.Sc.	16	20.0	28	35.0
M.A./M.Sc.	14	17.5	22	27.5

Instruments

The following instruments were used to collect data:

Demographic Sheet Form. A demographic sheet form which comprised of the participant's information such as age, monthly family income, education, type of family system was filled by each participant.

DSM-5 Cross-cutting Measure for Depression (APA, 2013). It has been developed to identify depression in individuals aged 18 years or older. The tool is an 8-item measure assessed on a 5-point Likert scale (1 = *Never* to 5 = *Always*). The final scores can range from 8 to 40 with higher scores indicating greater severity of depression. It has been developed based on the DSM-5 criteria of

depression (American Psychiatric Association, 2013) and thus is considered valid worldwide. It was translated in to Urdu to be used on indigenous sample through the MAPI guidelines of tool translation. The scale was translated in Urdu by 3 psychology professionals which was, afterwards, collated into one version. The obtained version was then translated back in to English for further confirmation. The scale emerged at the last step was compared with the original test and any relevant changes were done.

Severity Measure for Depression (APA, 2013). This measure has been adapted from the Patient Health Questionnaire-9 (Kroenke, Spitzer, Williams, & Löwe, 2010) to assess the severity of depressive symptoms in individuals aged 18 years and older. It is a 9-item measure assessed on a 4-point Likert scale (0 = *Not at all* to 3 = *Nearly Every day*). Total score on the scale ranges from 0 to 27 with higher scores indicating greater severity of depression. An Urdu version of the test was formulated through forward and backwards translations according to the MAPI guidelines for valid applicability on the indigenous sample in the present study.

Silencing the Self Scale. It is a 31-item measure formulated by Jack and Dill (1991). The scale measures suppressed feelings based on expectations from others and how individuals prefer others' choices over their own. The scale is divided into four subscales i.e., Externalized Self-Perception (Item 31: 'I never seem to measure up to the standards I set for myself'), Care as Self-Sacrifice (Item 4: 'Considering my needs to be as important as those of the people I love is selfish'), Silencing the Self (Item 30: 'I try to bury my feelings when I think they will cause trouble in my close relationship') and The Divided Self (Item 16: 'Often I look happy enough on the outside but inwardly I feel angry and rebellious'). The scale is measured on a 5-point Likert scale (1 = *Strongly Disagree* to 5 = *Strongly Agree*) in which five items (Item # 1, 8, 11, 15, 21) are reverse scored. Scores on the scale can range from 31-55 with higher scores corresponding to higher levels of self-silencing and vice versa. High reliability has been reported for this scale, with a Cronbach's alpha coefficient of 0.91. Urdu translation of the scale provided by the author was used. The reliability of the scale for the current study was found to be .86.

Dyadic Adjustment Scale. Originally developed in 1976 by Spanier and revised by Busby, Christensen, Crane, and Larson (1995), the scale was designed to measure relationship satisfaction. It has 3 sub-scales including Dyadic Consensus (the degree to which

respondent agrees with partner), Dyadic Satisfaction (the degree to which respondent feels satisfied with his/her partner), and lastly Dyadic Cohesion (the degree to which both partners participate in activities together). The scale has 14 items which are to be scored on a 5 or 6 point Likert scale. Scores on the scale range from 0-69 with higher scores indicating greater relationship satisfaction while lower scores indicate greater distress in relationship. Sample items of the scale are: 'How often do you or your partner quarrel', 'Do you and your mate engage in outside matters?' etc. The Cronbach's alpha for the scale is 0.90 hence indicating a highly reliable measure. The test was also translated in Urdu based on the MAPI guidelines of forward and backward translation in the present study.

Procedure

The study was initiated by obtaining permission from the Medical Superintendents and Head of Departments of general and psychiatry wards of hospitals. Participants were recruited after a psychiatrist referred them and they were screened through the DSM-5 cross cutting measure for depression. Women without depression were selected from the general wards of hospitals. Only those women were included in Group 1 who scored above the cut off score that is, 17. The cross cutting measure for depression was also attempted by Group 2 to confirm that scores were below cutoff. After the allocation of participant to relevant groups, silencing the self scale and dyadic adjustment scale was filled by each respondent. The severity measure for depression was attempted by Group 1 only. Ethical responsibilities were confirmed by informing participants with all necessary information about the research and guiding them about their rights. Informed consent was signed, confidentiality was ensured and any kind of physical or psychological harm was eliminated, Data obtained was then fed into the Statistical Package for Social Sciences (Version 21.0) for descriptive and inferential analyses.

Results

Inferential statistics including *t*-test, Pearson Product Moment Correlation, and regression analysis were performed on the data. The *t*-test was performed to check the differences of variables between both groups. Correlation explained the relationship of variables in both groups while regression elaborated the role of self-silencing and marital adjustment in predicting level of depression in the group of women with depression.

Table 2 presents *t*-values of self-silencing and marital adjustment and their subscales to demonstrate the difference of depression scores in both groups.

Table 2

Differences Between Women With and Without Depression on Study Variables (N = 160)

Variables	Women with Depression (<i>n</i> = 80)		Women without Depression (<i>n</i> = 80)		<i>t</i> (158)	<i>p</i>	95% CI Cohen's <i>d</i>		
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			<i>LL</i>	<i>UL</i>	<i>d</i>
CCMD	28.41	6.56	11.86	2.93	20.59	.00	14.96	18.13	0.85
Self-silencing	110.4	17.3	94.7	20.22	5.29	.00	9.85	21.55	0.83
Ext. Self-Percep.	21.1	6.94	15.87	5.25	5.38	.00	3.31	7.15	0.85
Care as SS	33.2	5.01	29.9	6.53	3.6	.00	1.49	5.13	0.57
Silencing the Self	31.9	5.71	29.10	6.56	2.96	.00	0.95	4.79	0.46
Divided Self	24.1	4.96	19.8	5.48	5.69	.00	2.64	5.90	0.81
DAS	41.48	14.61	19.83	5.48	-9.48	.00	-20.7	-13.5	1.96
Dyadic Cons.	18.89	6.33	25.03	3.99	-7.34	.00	-7.80	-4.49	1.16
Dyadic Satis.	12.39	4.74	17.54	1.90	-9.01	.00	-6.27	-4.02	1.42
Dyadic Cohesion	10.2	5.55	16.	3.12	-8.14	.00	-7.20	-4.39	1.20

Note. CCMD = DSM-5 Cross cutting measure for Depression; Ext. Self-Percep. = Externalized Self-Perception; SS = Self Sacrifice; Cons. = Consensus; Satis. = Satisfaction; DAS = Dyadic Adjustment Scale.

The *t*-test reveals significant differences of self-silencing and marital adjustment among both groups. This implies that women with depression have a significantly higher score on self-silencing than women without depression. On the contrary, women without depression have significantly higher scores on marital adjustment than women with depression. The results prove that the depressed group tends to have a more silenced self while the non-depressed group had better marital relationships.

Pearson Correlation was used in order to determine the direction and significance of relationships between the study variables. Correlation analysis reveals that depression has a significantly positive relationship with self-silencing and significantly negative relationship with marital adjustment for women with depression (see Table 3).

Table 3

Pearson Correlation Among Study Variables in Women With and Without Depression (N = 160)

Variables	Women With Depression (n = 80)			Women Without Depression (n = 80)		
	1	2	3	1	2	3
1. Depression	-	.28*	-.61**	-	.21	-.12
2. Self-silencing		-	-.21		-	-.03
3. Marital Adjustment			-			-
<i>M</i>	28.41	110.4	41.47	11.86	94.73	16.00
<i>SD</i>	5.56	17.12	14.62	2.94	20.23	3.12

* $p < .05$. ** $p < .01$.

Findings presented in Table 3 also implies that depression is associated with a higher trait of self-silencing and people with higher depression ratings have a lesser chance of maintaining satisfactory marital relationship. Non significant correlations can be seen in the non-depressed group which implies that non-depressed women do not show any relationship between self-silencing, marital adjustment and depression.

Linear regression was performed on the depressed group data to assess if self-silencing and marital adjustment predicted depression.

Table 4

Summary of Linear Regression Analysis for Variables Predicting Depression (N= 160)

Variables	<i>B</i>	<i>SE</i>	β
Externalized Self-Perception	.23	.10	.16*
Care as Self-sacrifice	-.10	.11	-.06
Silencing the Self	.13	.11	.08
Divided Self	.07	.13	.04
Dyadic Consensus	-.12	.12	-.08
Dyadic Satisfaction	-.97	.18	-.44**
Dyadic Cohesion	-.40	.15	-.22**
<i>R</i>			.79
<i>R</i> ²			.62
ΔR^2			.62
<i>F</i>			35.03***

* $p < .05$. ** $p < .01$. *** $p < .001$.

Regression analysis indicates that three predictors explain 79% variance in the model ($R^2 = .62$, $F(152, 7) = 35.03$, $p < .001$). It was

found that externalized self-perception was a significant positive predictor ($\beta = .16, p < .05$) of depression. On the contrary, dyadic satisfaction ($\beta = -.44, p < .01$) and dyadic cohesion ($\beta = -.22, p < .01$) were significant negative predictors of depression.

Discussion

The significant increase in prevalence of depression, especially in women, called upon a study examining factors contributing to depressive symptoms in this population. The current study aimed to compare women with and without depression on self-silencing and marital adjustment and to see their relationship with depression. Results from analyses confirmed the first hypothesis that self-silencing was more prevalent in women who were depressed while they were less adjusted with their spouses when compared to women who were not depressed. These findings are in line with the previous literature which has repeatedly confirmed a strong link of self-silencing behavior with the symptoms of depression (Flett, Besser, Hewitt, & Davis, 2007; Harper & Welsh, 2007; Jack & Ali, 2010; Whiffen et al., 2007). Women who are less expressive and maintain an external locus of control tend to interpret their own identity from the eyes of other people. Their primary focus is to keep others happy even if it is on the account of their own contentment. The continuing pressure to impose the identity of a 'good woman' or a 'good wife' contributes to a cycle of stress, sacrifice and reward. Even if the reinforcement is small, woman then try to achieve greater acceptance by an even bigger sacrifice. Along this way, they not only lose contact with their self-identity but also become more prone towards anxiety and depressive symptoms (Jack & Dill, 1991; Reyome, Ward, & Witkiewitz, 2010; Smolak, 2010).

The study also revealed that depressed women showed lesser marital adjustment as compared to women without depression confirming the second hypothesis. These result findings are augmented with similar research results of Jahromi, Zare, Taghizadeganzadeh, and Koshkaki (2015) that stated that marital adjustment of women with depression is worse than women without depression. It was seen that women with depression had lesser cohesion, satisfaction and consensus within their marital relationships. This shows that women with depression are more likely to face problems in marital adjustment with their spouses. Stress, tension and worry affect a woman's household responsibilities so she becomes unable to fulfill her duties at home. Not only does her personal health

get affected but a congenial home environment may not be maintained which worsens her relationship with her husband and in laws. Researchers imply that women are more subjected to stress and Depression after marriage so these two reasons become a cause of intolerance and irritation towards their spouses. The piling up of frustration and unexpressed feelings gradually leads to miscommunication between the two and the disruption of the marital relationship (Hashmi, Khurshid, & Hassan, 2007).

The results also confirmed the fourth and fifth hypothesis stating that self-silencing and marital adjustment are predictors of depression. Marital conflict, act of self-silencing and mental health has been studied and explained through research by Whiffen et al. (2007) proposing that women tend to silence themselves when they think their verbalizations will create a conflict with their spouse. Regardless of any external or overt conflict, they are hesitant to advocate their demands or opinions as they believe that it will jeopardize their relationship even further. Their research corroborates our findings that women judge themselves by strict external standards and fake compliance when in reality there is conflict of opinion. Their behaviors become their habit which in turn contributes highly towards multiple facets of depression. Ogletree (2014) further asserted that women who have higher intentions of maintaining marriage than men resulting in a higher degree of sacrifice. These sacrifices are not only monetary or time dedication rather suppression of voices, anger inhibition and tendency to compliance even when there is disagreement. The objective of increasing harmony and decreasing conflict is thus, done at the risk of developing depression.

Externalized self-perception served as a predictor of depression indicating that a part of self-silencing contributes towards the development of low mood, low self-esteem and a general loss in pleasure (Mueller, Pechtel, Cohen, Douglas, & Pizzagalli, 2015). Having an external self-perception means that the individual gives someone else control (Clarke, 2004) allowing his surrounding people to define him and give them authority to comment, praise or criticize him. The individual, instead of looking at the reality, tends to absorb information thrust upon by others and hence, shapes his self-perception according to the feedback given. The individual hearing from someone that he/she is worthless will start believing in the mere statement regarding it is fact. There will be no mental filter attached creating a dissonance between what actually is and what the person believes to be true. This might give way to feelings of worthlessness, hopelessness, feelings of rejection, distancing with partners and symptoms of depression thus proving that externalized self-perception

may in fact predict depression. Similarly, dyadic cohesion and dyadic satisfaction were two negative predictors of depression. Couples satisfied with each other and sharing a stronger bond present with lesser degree of depressive symptoms as partners may rely on one another. Artigas, Mateu, Vilaregut, Feixas, and Escudero (2017) propose that mental health can broadly affect dyadic adjustment that is marital partners may help their spouses to improve mental lives, eliminating causes of stress. Similarly, Clout and Brown (2016) also proposed a predictive relationship between marital relationship quality with mental health.

In majority of the world's population, particularly in developing countries such as Pakistan, domestic work is handled by women, while outdoor activities are the responsibility of men. People tend to keep the notion that women are to produce children, feed and educate them, along with keeping their husbands satisfied. They may be considered and treated as the property of their husband and are not allowed to defy his orders, needs or opinions. Domestic violence against women is widespread and rarely brought to public notice or punished unless the woman dies or suffers gruesome injuries (Jalal-ud-din, & Khan, 2008). An inferior role in marriage makes women unable to express their needs openly. In Pakistan, it is considered a disgrace if a woman dares to speak in front of males especially if her husband. Not following his commands or requests makes the wife disrespectful or ill-mannered. Furthermore, the society fuels such thinking by molding religious verses into patriarchy-favorable statements making it impossible for the women to defend her rights. Girls are brainwashed since their childhood to not raise their voices against their brothers or father. Such guidance and environment creates a silenced woman from the start who finds satisfaction and pleasure in others' demands and does not about her own identity. Most women in Pakistan are unable to stand for their rights or raise their voices in a marriage as they remain socially and culturally constrained by the stereotypic notions of a 'good woman' or a 'good wife'. They are unable to express their frustrations and anger and remain in a constant conflict between their personal and interpersonal needs.

This shows that remaining contented in marriage is not a choice but an obligation for most women in Pakistan where the whole responsibility of maintaining the marriage lies on her shoulders only. Quieting themselves and internalizing their anger without its proper expression to the respective individual makes her prone towards depressive symptoms thus creating a cycle of depression and poor marital adjustment.

Limitations and Suggestions

The current study focuses psychiatric population while further research can emphasize the general community sample to screen out depressive symptoms and the tendency to silence oneself. The use of quantitative surveys and instruments could not make it possible to collect subjective experiences and perspectives. Future research can be conducted through interviews to collect rich, in depth information from both men and women.

Implications

This study helped us to understand the mental health of women and how lack of communication, inhibition of expression and suppression of conflicts can lead to disruption in marriage. These findings would thus help couple counselors, mental health workers and psychologists to help spouses develop better communication and understanding of each other. Mental health workers could also use these findings to work with social workers and identify women expressing stress in daily house surroundings and how to actively cope with their feelings. Moreover, the study may help in the level of assertiveness training that would be helpful for women.

Conclusion

It can be concluded from the above results and discussion that women with depressive symptoms tend to have a more silenced self and are less adjusted in their marriage than women without depression. This implies that depression is linked to a decreased ability to convey one's emotions, desires, wants, needs and opinions. Not only does this affect the woman's psychological health but also disrupts their marital relationship by diminishing the mutual bond and affecting dyadic satisfaction.

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