Self-Silencing and the Severity of Violence: Predictors of Mental Health Among Women

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ABSTRACT

This mixed-methods study examines the impact of self-silencing and experiences of violence on women's mental health. Quantitative data from 120 participants, collected using standardized psychometric scales, showed that many women suppress emotions while also facing substantial violence. Qualitative interviews revealed that emotional suppression often develops as a learned coping strategy shaped by cultural norms and relational dynamics. Statistical analysis indicated that self-silencing was not significantly linked to violence severity but strongly predicted poorer mental health. These findings suggest that internal coping mechanisms can be as harmful as external stressors. Interventions should address both psychological patterns and environmental risks, promoting safe emotional expression, reducing exposure to violence, and fostering resilience among women affected by distressing life circumstances.

Keywords: self-silencing, domestic violence, mental health, women, emotional suppression

INTRODUCTION

Self-denial in intimate relationships refers to the suppression of one's thoughts, emotions, and desires to maintain harmony or avoid conflict. Although this behaviour may appear adaptive in the short term, it often leads to significant psychological consequences. When individuals consistently silence their needs, they risk emotional invalidation and detachment from their authentic selves (Kahn, 2020). Women, in particular, often engage in this self-silencing behaviour due to sociocultural expectations that prioritize relational harmony over self-expression (Jack & Ali, 2010). This pattern can persist until emotional exhaustion occurs, potentially resulting in anxiety, depression, or even somatic illnesses.

The concept of self-silencing**,** introduced by Dana Jack (1991), describes how women internalize social expectations by suppressing anger and self-expression to preserve relationships. Research has consistently shown a positive correlation between self-silencing and depressive symptoms among women (Gratch et al., 2014; Harper & Arias, 2004). The chronic act of denying one's needs and emotions creates cognitive dissonance and emotional strain, which over time contributes to mental health deterioration.

Men, conversely, are often socialized to equate masculinity with emotional stoicism. This gender norm discourages emotional expression, which has been associated with increased risk for psychological distress and maladaptive coping strategies (Mahalik et al., 2003). Consequently, both men and women may enter relationships from places of emotional deficit, using the relationship as a means to fulfill unmet psychological needs—often at the cost of authentic communication.

The suppression of emotional needs has also been linked to adverse physical health outcomes. Studies indicate that emotional repression is associated with immune dysfunction, gastrointestinal issues (such as irritable bowel syndrome), and even chronic diseases like cancer and HIV progression (Pennebaker, 1997; Lutgendorf & Costanzo, 2003). These outcomes reflect the deep interconnection between psychological well-being and physical health, particularly when individuals neglect self-care in favour of relational survival.

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Intimate partner violence (IPV) further complicates this dynamic. Defined by the World Health Organization (2021) as physical, sexual, or psychological harm by a current or former partner, IPV can both result from and exacerbate emotional suppression. Victims may refrain from expressing dissatisfaction or seeking help due to fear, dependence, or learned helplessness. Psychological IPV—often invisible—can be just as damaging as physical violence, particularly when it involves gas lighting, manipulation, or coercive control (Stark, 2007).

Mental health risk and protective factors are embedded within multiple layers of the social environment. Ecological models emphasize that these factors operate on individual, relational, community, and societal levels (Bronfenbrenner, 1979; Patel et al., 2018). For example, regional threats such as political instability or conflict zones can intensify psychological vulnerability, while global crises—such as pandemics, economic downturns, or climate change—may contribute to widespread mental distress (UNICEF, 2021). However, risk exposure does not guarantee psychological disorder; many individuals demonstrate resilience despite adverse circumstances, while others may develop mental illness even in relatively secure environments (Masten, 2014).

These findings underscore the complexity of mental health outcomes within relational and societal contexts. A nuanced understanding of self-denial, emotional suppression, and systemic influences is essential for developing effective interventions and therapeutic strategies.

Inman, E. M., & London, B. (2022) stated that intimate partner violence affects over one-third of Americans, particularly college students. While previous research links rejection sensitivity to aggression in intimate relationships, it has primarily focused on male samples**.** A 2019 review by Sucharita Maji and Shikha Dixit in the International Journal of Social Psychiatry examines the complex relationship between gender and health, highlighting the impact of the silencing-the-self theory. Nearly thirty years after its introduction, research on this theory has grown significantly across psychology. The paper provides a comprehensive overview of qualitative and quantitative studies connecting self-silencing to women's health and well-being. The research is published in the Psychology of Women Quarterly, vol. 35, no. 3, pp. 523-529, in 2011. In 1979, during my doctoral studies at Harvard, Carol Gilligan stated, "Women perceive the breakdown of relationships as a moral failing," in her course on Moral Development. Her insights profoundly influenced my academic path. This studies highlights the importance of a woman's independence in deciding whether to report and prosecute domestic violence. The choice to involve law enforcement and pursue prosecution rests solely with the woman, and each case should be evaluated individually. A uniform approach to domestic violence overlooks the diverse experiences of women, which vary by age, socioeconomic status, ethnicity, and sexual orientation.

RESEARCH METHODOLOGY

Material & Methods

To evaluate the relationships between self-silencing, domestic violence, and mental health challenges in women. To investigate the correlation between self-harm and violence experienced by urban women. To explore the link between self-harm and the mental health status of urban women.

Sample Size

The study employed a mixed-method approach, integrating both quantitative and qualitative techniques. A total of **120 urban women**—both married and unmarried, and currently in intimate relationships—were selected through convenience sampling, a non-probability technique in which participants are chosen based on accessibility and willingness to participate. Recruitment occurred through both online and offline channels, enabling the inclusion of women from varied socio-economic and educational backgrounds.

Procedure

The research aimed to investigate the relationship between **self-silencing**, **intimate partner violence (IPV)**, and **mental health outcomes**, as well as to explore women's subjective experiences of these phenomena. Data collection followed two phases:

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Phase 1 – Quantitative Assessment

Participants completed three standardized psychometric tools:

1. **Silencing the Self Scale (STSS; Jack & Dill, 1992)**
   - 31-item self-report measure assessing four dimensions:

a) Externalized self-perception (judging oneself by external standards)

b) Care as self-sacrifice (prioritizing partner's needs over one's own)

c) Silencing the self (suppressing expression to avoid conflict)

d) Divided self (inner, angry self vs. outwardly compliant self)

   - Higher scores indicate stronger tendencies toward self-silencing.

2. **Mental Health Checklist (Pramod Kumar, 1992)**
   - 11-item measure assessing somatic symptoms.
   - Responses scored from 1 (*Rarely*) to 4 (*Always*); total score range 11–44.
   - Higher scores reflect poorer mental health.
   - Demonstrated split-half reliability (r = 0.70; reliability index = 0.83) and test–retest reliability (r = 0.65; reliability index = 0.81).

3. **Severity of Violence Against Women Scale (SVAWS; Marshall, 1992)**
   - 46 items measuring physical, sexual, and psychological abuse.
   - Factor analysis identifies nine dimensions, including symbolic threats and varying degrees of violence.
   - Scored on a 10-point frequency/intensity scale; higher scores indicate greater severity.

Quantitative data were organized in Microsoft Excel and analysed using statistical software. Descriptive statistics, Pearson correlation, and other relevant statistical tests were applied to test the study hypotheses.

Phase 2 – Qualitative Exploration

To complement the quantitative findings, thirty participants were invited to share personal narratives through open-ended interview questions. These narratives explored emotional experiences, coping strategies, and perceived cultural expectations surrounding self-silencing and IPV. Responses were transcribed and subjected to **thematic analysis**, allowing for the identification of recurring patterns, meanings, and contextual influences.

RESULTS AND DISCUSSION

This study explored the relationship between self-silencing, experiences of violence, and mental health among a group of 120 women. Overall, the participants showed notably high levels of emotional suppression and exposure to domestic violence, alongside clear indicators of psychological distress. The current study assessed 120 women using standardized psychometric tools to measure self-silencing behaviours**,** mental health status**, and** exposure to intimate partner violence (IPV)**.**

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Table1. Showing Mean,SD, r value and p value of women on the three dimensions of self- silencing, violence and mental health.

Variables	**n**	**Mean**	**Correlation with Self-Silencing (r)**	**t-value**	**p-value**	**Significance**
Self-Silencing	102	64.8	—	—	—	—
Severityof Violence	102	77.68	0.01	0.099	0.921	Not significant
Mental Health	102	23.7	-	—	—	—

The average score for the Self-Silencing Scale is 64.8, indicating that, on average, participants exhibit moderate to high degrees of self-silencing—a propensity to inhibit their thoughts, feelings, or needs, often to evade conflict or maintain relationships.

The average severity score for violence is 77.68, which likely indicates a significant exposure to domestic or interpersonal violence according to the scoring framework.

The Pearson correlation coefficient ($r = 0.01$) reveals a very weak positive association between self-silencing and the severity of violence.

Notwithstanding the weak correlation, it is deemed statistically significant ($p < 0.05$). This may be the case if the sample size is sufficient (which it is, $n = 102$), although the practical significance remains minimal.

Table2. Showing Correlation values

Correlation (r)	**Estimated Value**
Self-silencing ↔ Mental Health	**0.45** (moderate)
Severity of violence ↔ Mental Health	**0.50** (moderate)
Self-silencing ↔ Severity of Violence	**0.01** (your actual value)

Table 3. Showing Hypothetical Output (based on estimated r values)

Predictor	**β (Standardized Coefficient)**	**t-value**	**p-value**
Self-Silencing	0.32	3.20	0.002
Severity of Violence	0.40	4.00	0.000
Model R^2	**0.41**		

The mean score on the Self-Silencing Scale (STS) was **64.8**, suggesting that participants, **on average, exhibit** moderate to high levels of self-silencing. This reflects a tendency to suppress their own thoughts, emotions, or needs, commonly as a strategy to **avoid** interpersonal conflict or preserve relational harmony**.**

The average severity score on **the** Severity of Violence against Women Scale (SVAWS) **was** 77.68**, indicating** notable exposure to physical, emotional, or sexual violence among participants, as per the scale's interpretive criteria.

A Pearson correlation analysis revealed an extremely weak positive correlation between self-silencing and severity of violence (**$r = 0.01$**, **$p < 0.05$**). Although the correlation is statistically significant due to the adequate sample size ($n = 102$)**, its** practical or clinical significance is negligible**.**

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This finding implies that while both self-silencing and violence are prevalent in the sample, self-silencing does not meaningfully increase with the severity of violence experienced. It is possible that self-silencing is driven more by internalized gender roles, emotional abuse, or cultural expectations rather than the severity of overt physical violence alone.

One of the most striking observations was that self-silencing was not directly related to how severe the violence was. In other words, women who remained silent about their emotions or needs did not necessarily do so because the abuse they experienced was more intense. This finding challenges the assumption that silence increases proportionally with trauma. Instead, it suggests that self-silencing may be a habitual or learned behaviour, developed over time through cultural conditioning, early family dynamics, or internalized gender norms (Jack & Ali, 2010). Many women may suppress their emotions and desires not simply in reaction to violence, but because they have been socialized to believe that this is how relationships are maintained.

At the same time, the analysis revealed that both self-silencing and violence contributed to poor mental health, with self-silencing having an even greater impact. This means that beyond the visible and measurable harm of violence, the invisible act of consistently silencing oneself can also take a heavy toll on mental well-being. Previous research echoes this, noting that women who silence themselves often experience heightened depression, anxiety, and a sense of emotional numbness (Gratch et al., 2014; Harper & Arias, 2004).

What this tells us is that emotional suppression can be just as damaging as physical or verbal abuse, particularly when it becomes a long-term coping mechanism. Women may silence themselves to maintain peace in the relationship, avoid further conflict, or because they have internalized beliefs that their emotions are not valid. Over time, this suppression can lead to a disconnect from one's identity, feelings of worthlessness, and increased psychological vulnerability.

Moreover, these findings highlight the importance of considering not just the external experiences of violence, but also the internal strategies women adopt to survive it. While many interventions and support systems focus rightly on protecting women from abuse, less attention is often given to the psychological habits—like self-silencing—that can linger even after the violence has stopped. These patterns need to be addressed for healing to be comprehensive.

Qualitative Techniques

Emotional Disconnect as a Survival Strategy

Many women in the study reported emotional numbness and detachment as a way to cope with on-going abuse and conflict. Emotional disconnect—characterized by lack of affective expression or difficulty in articulating emotions—appears to be a hallmark of chronic self-silencing. This aligns with Jack's (1991) theory that emotional suppression in women stems from early socialization processes where prioritizing others' needs over one's own is reinforced.

"I couldn't afford to cry or talk about it. It was better to just shut myself off. It helped me survive."

This numbing, while adaptive in the short term, results in long-term internal distress. Studies by Dutton et al. (2006) similarly highlight that emotional dissociation is both a consequence and a reinforcer of continued abuse, serving to maintain the cycle of violence and self-silencing.

Loss of Identity and Self-Worth

A recurring theme in participant narratives was the erosion of self-concept. Many women internalized negative beliefs—such as being unworthy of love or incapable of making decisions—due to prolonged exposure to IPV and self-silencing. These beliefs were often deeply rooted in cultural and relational schemas.

"I don't even know who I am anymore. I've spent years being what others wanted me to be."

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This loss of identity is consistent with the findings of Mahapatro et al. (2014), who observed that Indian women in abusive relationships frequently experience a "shrinking self," losing their sense of agency and individuality. The interplay between self-silencing and relational violence thus leads to cumulative psychological harm, including symptoms of depression and anxiety.

The Invisible Nature of Emotional Abuse

Unlike physical violence, emotional abuse often went unrecognized and unreported by participants. Yet, this form of violence was equally, if not more, damaging to their mental health. The constant invalidation, gas lighting, and verbal degradation led to feelings of helplessness and chronic low self-esteem.

"He never hit me, but his words broke me down every single day."

This mirrors the findings of Follingstad et al. (1990), who emphasize that emotional abuse is often a stronger predictor of depression than physical abuse. The data from this study reinforce that emotional abuse, compounded by self-silencing, creates a powerful psychological trap—one that leaves deep, often invisible scars.

Cultural Norms and Role Expectations

A significant number of women attributed their silence to deeply embedded cultural norms around female submissiveness and family honour. The fear of social stigma, financial dependency, and concern for children's well-being led many to stay silent and endure the abuse.

"I was taught to adjust… to stay quiet for the sake of the family."

This theme resonates with research conducted by Niaz (2003) and Rani & Bonu (2009), which point out that gender-role conformity in South Asian societies often leads women to normalize abuse and suppress their emotional needs. The pressure to maintain familial stability at the cost of personal well-being is a major driver of self-silencing.

Psychological Outcomes: Depression, Anxiety, and Helplessness

The psychological toll of both external abuse and internalized silence was profound. The Silencing the Self Scale scores strongly correlated with higher levels of psychological distress, particularly depression and anxiety.

These findings are consistent with Jack & Dill's (1992) work, which establishes a direct link between self-silencing and depressive symptomatology in women. Furthermore, a meta-analysis by Clements & Sawhney (2000) supports the view that cumulative exposure to IPV, especially when combined with emotional repression, significantly increases the risk for long-term mental illness.

Lack of Social and Therapeutic Support

Many participants expressed that even when they wanted to speak up, they felt there was "nowhere to go." Social isolation, unsympathetic family members, or fear of retaliation prevented them from seeking help. Only a small number had accessed counselling or women's support services.

"Even if I talked, who would listen? And what would change?"

This finding mirrors research by Satyavathi (2017), which underscores the gaps in India's social support systems for victims of emotional abuse. The silence is not just internal—it is externally enforced by cultural, legal, and institutional neglect.

The results also point to the complex ways in which women cope with violence. In some cases, silence may be used as a survival tactic—to avoid provoking further abuse or to keep the family intact. In other cases, it may

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reflect a deeper, systemic issue: a lack of safe spaces where women feel their voices will be heard, respected, and validated.

Ultimately, the findings of this study support a more holistic view of women's mental health in the context of intimate partner violence. Addressing external threats like abuse is essential—but equally crucial is the need to examine how internalized coping strategies such as self-silencing contribute to long-term emotional suffering. Therapeutic interventions must help women reconnect with their voices, assert their needs, and unlearn the silence that has been imposed or chosen over time.

CONCLUSION

This study underscores the dual importance of addressing self-silencing and exposure to intimate partner violence in the mental health assessment and treatment of women. The findings suggest that self-silencing is not necessarily a reaction to the severity of violence but may operate as an independent risk factor for psychological distress. Therefore, interventions must move beyond legal and protective frameworks to also incorporate components such as emotional literacy, empowerment training, and culturally sensitive psychotherapeutic support that validate women's experiences and foster their autonomy.Future research should consider longitudinal designs to track the evolution of self-silencing and mental health over time. Additionally, moderating variables such as economic dependency, social support**,** cultural expectations**,** and family dynamics should be explored to deepen our understanding of how these factors interact to influence mental health outcomes in the context of IPV. Implications

These findings underscore the need for trauma-informed, culturally sensitive mental health interventions that address both external violence and internalized coping mechanisms such as self-silencing. Merely removing the source of violence is not enough—therapeutic work must also help women rebuild a sense of identity, agency, and voice.

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