



GENDER DIFFERENCES IN SELF-SILENCING AND PSYCHOLOGICAL DISTRESS IN INFORMAL CANCER CARERS

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This study examined gender differences in self-silencing, the relationship between self-silencing and psychological distress, and reasons for self-silencing in informal cancer carers (329 women, 155 men), using a mixed-method design. Men reported greater self-silencing than women on the Silencing the Self Scale; however, women reported higher depression and anxiety, even though depression and anxiety were significantly correlated with self-silencing. These gender differences in patterns of self-silencing were explored in follow-up interviews with 34 women and 19 men carers, selected to represent a cross-section of cancer type and stage and analyzed using thematic decomposition and positioning theory. Both men and women reported self-silencing because of their desire to prioritize patient needs or to avoid conflict. However, women positioned self-silencing as a requisite for coping and demonstrated awareness of external judgement, reflecting self-policing linked to constructions of idealized femininity, in particular the positioning of women as natural carers. In contrast, men positioned self-silencing as a normal aspect of masculinity, regarding expressions of needs or feelings as signs of weakness and maintaining a positive front as a means of coping. These findings confirm that men and women self-silence for different reasons and with differential consequences for mental health. The significant association of self-silencing with depression and anxiety suggests that it is not an adaptive behavior for caregivers, supporting previous reports that avoidance of emotional discussion in couples living with cancer is detrimental to coping and to mental health.

It is now widely recognized that cancer is a relational experience, with the pattern of communication adopted by couples directly influencing coping and psychological well-being. Couples who are mutually responsive, attend to each other's needs, and talk openly about their stress are more able to engage in effective emotion- and problem-focused

coping (Zunkel, 2002), which allows them to find benefits in the cancer experience, such as personal growth and relationship closeness (Kayser, Watson, & Andrade, 2007; Manne, Ostroff, Winkel et al., 2004). This pattern of mutual communication has also been found to be associated with lower levels of distress for patients and partners and with higher levels of marital satisfaction (Badr, Acitelli, & Carmack Taylor, 2008; Manne et al., 2006; Ptacek, Ptacek, & Dodge, 1994). Conversely, many partners are overprotective toward the person with cancer, engaging in “protective buffering” in an attempt to prevent distress (Badr & Carmack Taylor, 2006; Kuijjer et al., 2000) or in “disengaged avoidance” (Kayser et al., 2007, p. 412), involving complete denial of cancer or its effects. Although these approaches may appear to be functional in protecting against suffering, they do not allow the partner to support the person with cancer (Kayser et al., 2007) and can alienate the patient (Badr & Carmack Taylor, 2006). Indeed, couples who avoid talking about the cancer or its emotional impact report higher levels of distress and lower levels of marital satisfaction (Badr et al., 2008; Kuijjer et al., 2000; Manne et al., 2006; Ptacek et al., 1994; Skerrett, 1998; Zunkel, 2002) as well as less supportive behavior within the couple (Manne, Ostroff, Winkel, Grana, & Fox, 2005).

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The larger cross sectional project evaluating the needs and experiences of informal cancer carers, from which this study was drawn, was funded by an Australian Research Council Linkage Grant, LP0560448, in conjunction with the Cancer Council New South Wales, Westmead Hospital, and Carers New South Wales. The chief investigators on the project were Jane Ussher and Phyllis Butow, and the partner investigators were Gerard Wain, Gill Batt and Kendra Sundquist. Thanks are offered to Mirjana Sandoval, Emilee Gilbert, Yasmin Hawkins, Tim Wong, Caroline Joyce and Lisa Hallab for research support and assistance.

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Self-Silencing and Gender

The protective buffering and avoidance of talking about feelings commonly found in couples coping with cancer is analogous to the pattern of self-silencing initially identified by Jack (1991) as an explanation for women's greater susceptibility to depression. Self-silencing is characterized as the propensity to engage in compulsive caretaking, pleasing the other, and inhibition of self-expression in relationships in an attempt to achieve intimacy and meet relational needs (Carr, Gilroy, & Sherman, 1996). However, this approach can lead to a self-division between an "outwardly conforming and compliant self" and an "inner self who is angry and resentful" (Jack, 1987, p. 177), described by Jack (1991, p. 169) as "the core dynamic of female depression." This pattern results because women are taught to believe that they are not loved for who they are, but for how well they meet the needs of others. The resultant silencing of desires and feelings, in particular anger (Jack, 1999), as well as the use of external standards against which to judge the self, can lead to feelings of worthlessness and hopelessness (Duarte & Thompson, 1999). A self-report questionnaire, the Silencing the Self Scale (STSS; Jack, 1991), which was developed to assess the intensity of self-silencing cognitive schema derived from culture, identified four distinct facets underpinning self-silencing behavior. "Externalized Self-Perception" reflects the tendency to judge the self by external standards; "Care as Self-Sacrifice" assesses the propensity to put the needs of others before the self; "Silencing the Self" involves the inhibition of thoughts, feelings, and behaviors in order to avoid relationship conflict or loss; and "Divided Self" assesses the tendency to behave in a compliant manner while feeling angry and resentful inside.

Self-silencing is not a pattern of behavior unique to women. In a number of studies, men reported levels of self-silencing equal to those of women (Cowan, Bommersbach, & Curtis, 1995; Jack & Dill, 1992) or even higher than women's (Cramer & Thoms, 2003; Duarte & Thompson, 1999; Gratch, Bassett, & Attra, 1995; Page & Stevens, 1996; Thompson, 1995; Whiffen, Foot, & Thompson, 2007). However, differences have been reported between women and men both in patterns of self-silencing and in the relationship between self-silencing and depression. For example, a factor-analytic study found that the Divided Self subscale did not appear as a construct for men, whereas it did for women. Instead, a factor of Autonomy/Concealment emerged uniquely for men, described as "an intention to prioritize one's own needs and to maintain a feeling of self-sufficiency, combined with the motivation of hiding what is perceived to be a potentially undesirable aspect of oneself from one's partner" (Remen, Chambless, & Rodebaugh, 2002, p. 154). Another study reported that the Care as Self-Sacrifice and Divided Self subscales were intercorrelated for women, but not for men, suggesting that women who prioritized the needs of others experience anger and a loss of self whereas men did not (Duarte & Thompson, 1999,

p. 159). Researchers have also reported that, whereas men report significantly higher self-silencing than women, men also report lower depression (Duarte & Thompson, 1999; Whiffen et al., 2007). These findings have led to the conclusion that further exploration of the reasons why men and women self-silence, and the consequences of this difference for psychological well-being, is needed (Cramer & Thoms, 2003; Remen et al., 2002). There is also a need to explore the development and function of self-silencing in different relational and situational contexts because much of the existing research on self-silencing has been conducted with student populations.

Gender and Psychological Distress in the Context of Cancer

Research and theory on self-silencing, depression, and gender has particular relevance in the field of cancer. It is now well established that gender is the key factor predicting psychological distress in both people with cancer and their partners (Hagedoorn, Sanderman, Bolks, Tuinstra, & Coyne, 2008), with women being significantly more likely to experience depression than men. In their recent meta-analysis, Hagedoorn et al. (2008) concluded that empirical work that examines distress or communication patterns in couples facing cancer needs to be supplemented by the introduction of theoretical models that acknowledge the primacy of gender. Equally, Miller and Cafasso (1992) argued that, rather than simply documenting gender differences in caregiving, we need to develop theoretically driven research that pays more attention to gender-role explanations of the experience of caring. One such theoretical model is self-silencing theory, which would view communication within relationships as central to women's adjustment to serious illness, such as cancer (Kayser, Sormanti, & Strainchamps, 1999), whether they are in the role of patient or carer.

There is evidence that women are more affected than men by the emotional well-being of others (Benyamini, Leventhal, & Leventhal, 2000; Hagedoorn et al., 2001) or by life events, such as cancer, which affect others (Kessler & McLeod, 1984; Taylor, 2006). This sensitivity may result in women self-silencing in order to put the needs of the other first, particularly if they are the partner or informal carer of a person with cancer, increasing their own risk of depression. Informal cancer carers do experience high rates of anxiety and depression, with 20–30% believed to be at high risk for psychiatric morbidity (Hagedoorn, Buunk, Kuijer, Wobbes, & Sanderman, 2000). Some studies even suggest that cancer-related distress is higher in informal carers than in people with cancer (Matthews, Baker, & Spikers, 2003) or cancer survivors (Matthews, 2003). Women carers report higher rates of depression and anxiety, as well as lower life satisfaction and quality of life ratings, when compared to men carers (Bookwala & Schulz, 2000; Hagedoorn et al., 2000; Hagedoorn et al., 2008; Payne, Smith, & Dean,

1999). Self-silencing is an unexplored potential explanation for these gendered patterns of distress.

Aims of the Present Study

The aim of the present mixed-method study is to explore gender differences in patterns of self-silencing, the relationship between self-silencing and psychological distress, and reasons for self-silencing in men and women cancer carers. Whereas previous research has examined self-silencing and psychological well-being in women with cancer who had young children (Kayser et al., 1999), there is no known published research to date that has examined self-silencing in informal cancer carers or gender differences in self-silencing in the cancer context. Previous research on cancer as a relational issue has focused on communication within intimate couple relationships, primarily in the areas of breast and prostate cancer (Hagedoorn et al., 2008, p. 20). The present study extends this analysis to look at communication between the person with cancer and his or her primary informal carer, and it includes a broad range of cancer types. This research will provide further insight into the relational context of coping with cancer, in particular the connection between avoidant patterns of communication and distress. However, it will also address the call for further examination of reasons why self-silencing occurs in women and men, with broader implications for the understanding of self-silencing as a gendered phenomenon.

METHOD

Participants and Procedure

Four hundred eighty-four informal cancer carers (329 women, 155 men) living in New South Wales (NSW), Australia took part in the study. "Informal carer" is defined as the primary person providing emotional and/or physical support for the person with cancer. All participants completed a self-report survey that examined their experience of cancer caring, self-silencing, and general well-being. Demographic details of the survey sample are presented in Table 1. From this group, 53 carers (34 women, 19 men), encompassing a range of cancer types and stages, took part in semi-structured interviews (see Table 1, interview sample). We did not collect data on socioeconomic status (SES), other than current employment status, because pilot research had indicated that a significant proportion of cancer carers were retired or currently not working (Ussher & Sandoval, 2008), rendering questions about income level as a measure of SES redundant. We did not wish to overburden participants with other questions about SES as it has not been reported to be a significant factor in cancer carer distress. We did not ask whether participants were living with the person with cancer, however, the majority of participants were married or in a long-term relationship with the person with cancer, suggesting that they were cohabiting.

Participants were recruited via cancer support groups, media stories in the local press, advertisements in cancer and carer-specific newsletters, hospital clinics, and The Cancer Council NSW Web site and helpline. Participants who were interested in taking part contacted the research team by e-mail or telephone and were sent an information sheet, consent form, survey, interview contact form, and reply paid envelope. Participants could also access the survey directly through a Web address published in advertisements to complete the survey online. A majority of participants completed the survey in the hard copy format (344) compared to the online format (140). Those completing the hard copy questionnaire were significantly older than those completing online ($M = 57$ years vs. 49 years), $t(468) = 6.61, p < .001$; were more likely to be male (80% of men vs. 67% of women), $\chi^2(1, 483) = 8.62, p = .003$; and reported lower depression ($M = 6.48$ vs. $M = 8.19$), $t(478) = -3.86, p < .001$, and anxiety ($M = 9.40$ vs. $M = 11.28$), $t(478) = -3.86, p < .001$. At the end of the survey participants were asked whether they would like to be considered to take part in a 1-hour interview to discuss their caring experiences in more depth. Of the 398 participants who responded positively to the invitation, by returning a form in a reply paid envelope, 53 were selected for interview, representing a cross-section of cancer types and stages, gender, and relationship with the person with cancer, as reflected in the larger study population. Whereas the mean length of time from diagnosis was statistically greater in the interview sample (see Table 1), $t(472) = -3.59, p < .001$, the median was more comparable (1.5 months, survey sample; 5.2 months, interview sample). There were a higher percentage of bereaved participants in the interview sample because a number of individuals selected for interview had become bereaved after having completed the questionnaire.

Two cancer carers nominated by a cancer consumer organization, "Cancer Voices," acted as consultants on the project, commenting on the design, method, and interpretation of results. Ethics approval was received from the University Human Research Ethics Committee and from 18 Area Health Authorities in NSW, from which participants were drawn.

Instruments

The STSS (Jack, 1991) is a standardized questionnaire consisting of 31 items measuring the extent to which individuals endorse self-silencing thoughts and actions, using a 5-point Likert scale. In addition to a global score, the four subscales are: Care as Self-Sacrifice (e.g., "Caring means putting the other person's needs in front of my own"), Silencing the Self (e.g., "I don't speak my feelings in an intimate relationship when I know they will cause disagreement"), Externalized Self Perception (e.g., "I tend to judge myself by how I think other people see me"), and Divided Self (e.g., "Often I look happy enough on the outside, but inwardly I feel angry and rebellious").

Table 1
Carer Characteristics for the Survey and Interview Samples

Variable	Survey Sample		Interview Subsample	
	N	M (SD) Range	N	M (SD) Range
Informal carer age	480	55.1 (13.2) 18–85	52	56.4 (12.3) 29–85
Person with cancer age	477	59.2 (11.6) 18–93	51	57.0 (14.1) 29–85
Years since patient's first diagnosis	474	0.6 (1.8) 1mth–23yrs	51	1.8 (3.1)* 1mth–12yrs
	N	%	N	%
Ethnicity:				
Aust/White European	456	94.4	50	96.2
Asian	22	4.6	2	3.8
Aboriginal	4	0.8	—	—
Not stated	1	0.2	—	—
Employment status:				
Employed full time/part time	185	38.6	22	42.3
Temporarily not working (due to caring responsibilities)	44	9.2	3	5.8
Retired	165	34.4	20	38.5
Home duties	46	9.5	2	3.8
Other ^a	39	8.0	5	9.6
Patient's cancer type:				
Brain	23	4.8	7	13.5
Breast	83	17.3	13	25
Colorectal/Digestive	62	12.9	6	11.5
Gynaecological	30	6.3	3	5.8
Haematological	51	10.6	1	1.9
Multiple Nonsexual	35	7.3	1	1.9
Multiple Sexual	19	4	3	5.8
Prostrate	33	6.9	6	11.5
Respiratory	29	6.0	7	13.5
Other ^b	61	12.7	3	5.8
Missing	54	11.3	2	3.8
Patient's stage of disease:				
No longer detectable	88	18.2	10	19.2
Early	43	8.9	6	11.5
Advanced	185	38.3	14	26.9
Not sure/applicable	142	29.6	11	21.1
Bereaved	22	4.6	11	21.1
Relationship with patient:				
Intimate partner	345	71	40	76.9
Child	57	11.8	2	3.8
Parent	37	7.6	4	7.7
Friend	18	3.7	3	5.8
Sibling	13	2.7	2	3.8
Other	10	2.1	1	1.9

^a“Other” includes: unemployed, student and nonspecified. ^b “Other” includes: Mesothelioma, Pancreatic, Bone, Melanoma, various, each less than 2%.
* $p < .001$.

The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983), is a 14-item validated self-report measure developed to measure anxiety and depression in nonpsychiatric populations. Each subscale, HADSA (anxiety) and HADSD (depression), has a maximum possible

score of 21, with a score of between eight and above recommended for “caseness,” the cutoff for clinical diagnosis. A score of 8–10 is categorized as borderline and a score of 11 and above is categorized as abnormal in relation to caseness (Bjelland, Dahl, Haug, & Neckelmann, 2002).

Statistical Analyses

One-way analyses of variance, with gender as the grouping variable and STSS and HADS scores as the dependent measures, were performed to test for gender differences. Pearson's correlations were used to assess associations between self-silencing, anxiety, and depression for the overall sample and for men and women separately. One-sample *t*-tests were used to assess differences between mean scores obtained in this study and published results on the STSS (Cramer & Thoms, 2003) and the HADS (Janda et al., 2007).

Interviews

An open-ended narrative interview, conducted on a face-to-face basis, was used to examine the experience and construction of care in the context of the broader caring relationship. The interviews were conducted at a venue convenient for the participants, including the university campus, Cancer Council NSW offices, or the participant's home. Interviewees were offered \$25 as a reimbursement for any travel expenses. The interview was audiotaped and lasted approximately 1 hour. Participants were sent a list of the question areas 1 week prior to the interview. At the beginning of the interview, participants were told: "today is an opportunity for you to chat to me about your experience as a carer, and to talk a little more in depth about some of the things you said in the questionnaire. The areas we cover will be those mentioned in the letter you received recently." The interviewer then asked about difficult and rewarding experiences; ability to take time out for self-care; support received from family, friends, and health professionals; emotional reactions to cancer and cancer caring; and communication of carer needs within the relationship (the focus of the present paper). In accordance with established protocols in qualitative research, sampling was discontinued when information redundancy was reached, and no additional information was forthcoming (Miles & Huberman, 1994).

Qualitative Analysis

All of the interviews were transcribed verbatim. After transcription, the interviews were independently read by three members of the research team in order to ascertain the major themes emerging and to develop a coding frame based on notions of consistency, commonality, and the function and effects of specific themes. The whole data set was then coded, line by line, by two of the researchers, after which a group meeting was held to discuss any new or unforeseen themes and to reevaluate the inclusion of themes which appeared with low frequency. The interpretation of these themes was conducted by a process of reading and rereading, as well as reference to relevant literature, following established protocols for thematic analysis (Braun & Clarke, 2006). More specifically, we undertook a "thematic decom-

position" (Stenner, 1993, p. 114), a close reading of the interviews which separates the text into coherent themes or narratives that reflect subject positions allocated to, or taken up by, a person. The interpretation of the data was conducted from within the framework of positioning theory (Davies & Harre, 1990), where it is assumed that narratives do not simply mirror a world "out there," but that they are constructed, creatively authored, rhetorical, replete with assumptions, and interpretive (Potter & Wetherall, 1986, p. 5; Reissman, 1993, p. 5), reflecting subject positions taken up or given to individuals that provide the context for the negotiation of experience and identity. Participants identified positive and negative experiences in relation to the self, the person with cancer, and others. One of the themes identified was self-silencing in relation to the person with cancer—the focus of the analysis presented in our study.

RESULTS

Gender Differences in Self-Silencing and Psychological Distress

The means and standard deviations for the global and subscale scores on the STSS and anxiety and depression subscale scores on the HADS are reported in Table 2 for women and men. In univariate analyses, men scored higher than women on STSS Global Self-Silencing, $F(1,478) = 7.77, p < .01, \eta^2 = .016$, Silencing the Self, $F(1,476) = 13.08, p < .001, \eta^2 = .027$, and Care as Self Sacrifice subscales, $F(1,477) = 36.32, p < .001, \eta^2 = .071$, with no significant gender difference observed in mean subscale scores on Externalized Self-Perception and Divided Self. For women, significant positive intercorrelations were found between all STSS subscales. For men, there were

Table 2

Means and Standard Deviations on the Silencing the Self Scale (STSS) and Hospital Anxiety and Depression Scale (HADS) for Women and Men

Variable	Women (<i>N</i> = 326)		Men (<i>N</i> = 154)		<i>P</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
HADS—Anxiety	10.39	4.71	9.01	4.44	.002
HADS—Depression	7.27	4.53	6.37	4.27	.040
Silencing the Self Scale					
Externalized	16.41	5.81	15.46	5.35	.089
Self-Perception					
Silencing the Self	25.05	7.45	27.61	6.71	<.001
Care as Self Sacrifice	27.39	6.61	31.35	6.89	<.001
Divided Self	16.89	6.73	16.42	5.70	.451
Global Score	85.30	21.15	90.84	17.70	.006

Note. Statistical significance testing of differences in means conducted in one-way analyses of variance with gender as the grouping variable.

Table 3
Correlations Between Scores on the Silencing the Self Scale (STSS) Subscales and Hospital Anxiety and Depression Scale (HADS) for Women and Men

<i>Variable</i>	<i>Externalized Self-Perception</i>	<i>Silencing the Self</i>	<i>Care as Self Sacrifice</i>	<i>Divided Self</i>	<i>Global Score</i>
<i>Women</i>					
HADS—Anxiety	.43**	.20**	.07	.40**	.34**
HADS—Depression	.33**	.23**	.10	.40**	.36**
Silencing the Self Scale					
Externalized Self-Perception		.40**	.21**	.50**	.70**
Silencing the Self			.54**	.45**	.86**
Care as Self Sacrifice				.01	.66**
Divided Self					.65**
<i>Men</i>					
HADS—Anxiety	.41**	.16	.06	.40**	.33**
HADS—Depression	.30**	.21**	.06	.42**	.33**
Silencing the Self Scale					
Externalized Self-Perception		.46**	.31**	.58**	.75**
Silencing the Self			.49**	.62**	.86**
Care as Self Sacrifice				.19**	.67**
Divided Self					.78**

** $p < .01$, two-tailed.

significant correlations between all but the Care as Self Sacrifice and Divided Self subscales (see Table 3). For both men and women, scores were higher than those found in a previous study of men and women in a relationship (Cramer & Thoms, 2003) for Global Self-Silencing, Silencing the Self, and Care as Self-Sacrifice; Divided Self was higher for women only, and Externalized Self-Perception was comparable for men.

The mean level of anxiety and depression of both genders was high and comparable to a previous sample of cancer carers (Janda et al., 2007). Although not used to formally diagnose participants in this study, 23% ($n = 113$) and 45% ($n = 216$) of the sample met the criteria for borderline and abnormal anxiety caseness, respectively. On the depression scale, 57% of the sample scored in the normal range, with 19% ($n = 90$) and 23% ($n = 112$) meeting the cutoffs for borderline and abnormal caseness, respectively. Women scored significantly higher than men on both the anxiety, $F(1,479) = 9.35$, $p < .01$, $\eta^2 = .019$, and depression subscales, $F(1,479) = 4.25$, $p < .05$, $\eta^2 = .009$.

Table 3 presents the correlations among global and subscale STSS and subscale HADS scores for women and men. For both genders, STSS Global Self-Silencing scores were significantly positively associated with both anxiety and depression scores on the HADS. Regression analysis identified that, for men, STSS Global scores accounted for 11% of the variance in HADS scores. For women, STSS Global scores accounted for 13% and 12% of the variance in HADSA and HADSD, respectively. Externalized Self-perception and Divided Self were associated significantly and positively with HADS anxiety and depression score for

both men and women. In contrast, Care as Self Sacrifice failed to reach significance with HADS subscales. A gender difference was observed on the correlations between the Silencing the Self and HADS subscales, with significant positive correlations found for women but not for men with respect to anxiety scores.

Self-Silencing Carer Needs and Concerns

In the interviews, the majority of participants reported that they did not express their own needs and concerns to the person with cancer. These concerns were extensive, including depression, anxiety, shock, loneliness, exhaustion, physical health problems, feelings of overresponsibility, and sexual needs. This particular pattern of self-silencing was explained in a number of ways, outlined in the following subthemes: prioritizing the needs of the patient, silence as a requisite for coping, men do not express vulnerability, and silencing anger to avoid conflict.

Prioritizing the needs of the patient. The most common explanation, adopted by both women and men cancer carers, was that the needs and concerns of the person with cancer should be prioritized and made the focus. As Ellen told us about her relationship with her friend with multiple cancers: “She didn’t need to hear anything about me, it was all about her at that point.” Or as Sally said about her husband with haematological cancer, “I tried to put all my feelings underground because I felt he needed to be the focus at that point so I really, I suppose, I went into limbo land.” Implicit in these accounts was a comparison of the

gravity or magnitude of the concerns of the person with cancer compared with those of the carer, with the carer always self-positioned as secondary. As Adam commented, "My wife's passing away, my wife's dying, I mean, I don't care about me." He added that he could not "see a relevance" in even thinking about his own needs when his wife had breast cancer. In a similar vein, Jenny said of her partner with brain cancer, "I didn't ever tell him [how badly I was coping] because I think for me I didn't want to burden him, you know, he was dealing with the whole of his life flashing before his eyes." Sean gave a comparable account of his caring for his wife with breast cancer:

The expressing needs and concerns, I meter everything I say to C. She's going through an even more personal experience than I am. She's facing her own death and I mean we all know that life's a terminal disease but, you know, she doesn't know how long she's got to live and I don't want to impose any more on her with regard to my needs and concerns than is absolutely necessary.

These are accounts of a desire to protect the person with cancer from the "burden" of carer concerns. In particular, carers did not want the person with cancer to be aware of the burden of care. As Donna told us, with reference to her mother with gynaecological cancer, "I probably didn't want her to worry at all about the fact that I was having a hard time doing it [caring]." The majority of participants positioned this prioritizing of the needs of the patient as a choice, a sacrifice which was made willingly as part of the caring role. As Ellen said, "I was so glad that I was able to do it. I'd never really questioned it . . . it was a gift to me to be able to do it," or as Adam commented, "she was my wife and I wanted to do everything." However, this experience did exact an emotional cost for the carers, often resulting in feelings of isolation and loneliness—a major theme within the interviews. Bella's description of her loneliness in caring for her husband with prostate cancer illustrates this point:

It was a harrowing, very lonely experience lying in bed with him at night knowing, well, he's a cancer patient, I'm his wife but I can't talk to him about really how I feel because I wasn't going to be here to dump all my stuff on him.

This pattern of self-silencing was often marked by significant self-sacrifice on the part of the carer, involving negation of their own physical and psychological needs, in order to put the needs of the patient first.

Silencing feelings as a requisite for coping. A second subtheme positioned self-silencing of the carer's needs within the relationship as a requisite for coping. These accounts described the suppression of the carer's needs as a necessity, partly because the caring role left no space for their concerns. As James told us, with reference to caring for his wife with advanced breast cancer, "I can't allow myself to get all stressed up over it. Because if I . . . who's

going to look after me, when I get crook [sick]." As a male participant, James was an exception because the majority of accounts in this subtheme were from women. There was a strong sense of obligation in these accounts, with self-silencing described as an inevitable aspect of the caring role. This point is illustrated by Diana and Jean, respectively, both caring for husbands with advanced prostate cancer: "I'm not allowed to show any sign of weakness"; "I had to continue, I didn't have a choice . . . I'd sort of gloss over it [feelings], I mean so I was coping." This silencing of their own needs was positioned as a normal aspect of the way they coped with life's responsibilities. Jean said, "I'm from the old school, you sort of . . . life went on no matter what, and you just had to," and Diana said, "being the strongest daughter and being the responsible one . . . No, Diana, you must be strong and you must carry on." Again, this restraint was described as difficult for the carer, as Olivia told us when describing caring for her friend with respiratory and bowel cancer:

The difficult part was having to help, having to control myself and help people cope. Right? So there were people that, you just had, you can't just go around weeping and wailing and gnashing your teeth and all of that sort of stuff, that wasn't the way M was doing it, that meant it wasn't the way I was doing it and I just had to help people cope.

Similarly, Diana said, "I just think the last four years have really taken their toll on me . . . I haven't coped with this well and I . . . I'm very short-fused." In many of the accounts of self-silencing in order to cope, participants talked of the importance of being seen to be coping by others, implicitly evoking external evaluation or judgment. Jenny's account of being "brave" when caring for her husband with brain cancer exemplified this point:

Things just started to build up and I think I tried to be so brave at work and I tried to be so brave in front of H and in front of my friends. . . . I was so determined to help H and to look like I was doing a good job as a carer and a wife that, yeah, I took on way too much (laughs).

At the same time, many participants talked of not receiving support from others because of the appearance that they were coping. As Diana told us "sometimes people don't even stop and think, 'Well, I wonder how poor Diana is actually coping?' And bothering to ask." Friends and family were also said to not look beneath the surface and see that the carer might need support. Hilary, who was caring for her husband with bowel cancer, described her grown-up children thus: "They just think, 'Oh, you know, everything's all right. Dad's got over this. Mum's cooking for dad. Yeah, he's eating. There's nothing more.' That's my impression." Maintaining a facade of coping thus had further consequences in terms of carer isolation and lack of support from others.

Men do not express vulnerability. The third explanation for the self-silencing of carer needs or concerns, given by a number of male participants, was that they never express their vulnerability so why should they behave differently in the context of cancer caring. Gary told us he had never expressed his feelings to his partner, who had recently died of respiratory cancer, either before or after her cancer diagnosis. Brian, caring for his wife with pancreatic cancer, told us that he “didn’t want to” discuss his feelings with her: “I couldn’t see any point in that. I mean, no, no, it didn’t even cross me [sic] mind.” He justified his behavior by positioning it as normal for men. “No. I’m fella, I’m not a girl. It’s different for men, I mean it’s totally different for men.” Drawing on similar constructions of stoic masculinity, Paul, who was caring for his wife with advanced breast cancer, described talking about feelings or asking for support as “an admission of weakness.” Lawrence was regretful that he didn’t have a more open pattern of communication with his sister, who had multiple cancers. He positioned their avoidance of “sloppy” conversation as “hard,” but somehow inevitable, because they were siblings: “You try and bottle them up and don’t show them [emotions], but it’s one of them things.”

A number of men carers talked not only of silencing their own needs, but also of putting up a positive front in order to facilitate coping. This facade was partly explained as a habitual pattern, as is evidenced by Denis’s account of “always smiling” when caring for his friend with gynaecological cancer: “I suppose when stuff like that happens then sadness creeps in and you don’t want it to, you try to keep it back at the door, stay away, if you see what I mean.”

The other explanation given for putting up a positive front was to protect the person with cancer, rallying them round in the face of despair. As Ed told us, “you drag everything you can that’s positive . . . that was basically my major job, to keep her spirits up. And even when you didn’t feel like it you felt you had to convince her that cancer is just a word not a sentence.” In a similar vein, Adam, caring for his wife with breast cancer, said “I would always try and get a positive spin on things and I wouldn’t let her go to sleep at nighttime thinking negative.” He described his experience as a soccer coach as “training” for his caring role, saying “I’ve always managed to get a positive out of [things].”

Many of the women carers also talked of the male patient not being willing to discuss his feelings, and this reticence being the reason for the absence of emotional communication in the relationship. Margaret described her husband, who had bowel, brain, and lung cancer, as “not being a person to express his emotions very much, he wouldn’t say much about it, I think he felt much more about it than he ever said about it.” Similarly, Maxine said she “would try to open up the conversation” with her husband who had brain cancer, but he “was not that sort of person . . . he was not a person who would dwell on what had happened to him, no. So I mean we didn’t have those [conversations].” Maxine commented that the fact that her husband “didn’t need

to discuss things . . . was harder for me than for him.” Kay tried to find out how her husband with pancreatic cancer was feeling, and he would simply say “‘oh, I’m good,’ and that’s the end of the conversation.” She described this as “a man thing,” concluding, “I think men don’t like to think that they are no longer in charge, especially of their own body.” This reluctance of male patients to discuss emotions functioned to silence any discussion of the carer’s needs and concerns. As Hilary told us in the following exchange:

Interviewer: Did he ever ask you how you were—how you were doing?

Hilary: No. No. And through those early stages I didn’t know how he was feeling. He wouldn’t talk much. There was one night we actually did start to talk, but he just broke down and he said, “Oh, don’t”—I can’t remember what he said now. It was like, “Oh, don’t say that” or something. I don’t know, I can’t remember. So I think after that I just—I just clammed up and I was really frightened to bring anything up at all.

Silencing anger to avoid conflict. The final subtheme within accounts of carer self-silencing in relation to the person with cancer concerned the silencing of the carer’s anger. Participants gave accounts of feeling angry about a range of issues, including lack of support, lack of time for self-care, relationship conflicts, patient behavior (such as refusal to eat food or accept external help), and decline in sexual activity within the relationship. The primary reason given for self-silencing in relation to anger was to avoid conflict in the relationship or to avoid upsetting the person with cancer, even if they were being “difficult.” As James said, “I feel very angry. I feel like, to just explode, yeah. And really just lash out at her. But I know I can’t because that would just make it even worse. So I just hold my tongue and just . . . just cop the abuse from her.” Gary gave a similar account: “I can’t win, you know. I just have . . . All I can do is just be here, and you know, be a punching bag for a little while longer. You know what I mean?”

All of the carers said that this silencing of anger was a change in their normal pattern of responding to the person with cancer. For example, Kay described her inability to retaliate toward her husband as “frustrating.”

He can flare up for no reason, well I don’t think it’s a reason. Well I have to walk away from that, I can’t retaliate. There’s absolutely no point, I mean he’s not responsible for what he’s saying and so there’s no point in me retaliating. Now that’s frustrating because you think you have every right to retaliate. And under normal circumstances you probably would.

Acceptance that the person with cancer might be moody or angry because of their illness and that tolerance on the part of the carer was required was a frequent retort in the interviews. This resignation is illustrated by the comments

of Paul and Cheryl, who cared for partners with breast and haematological cancer, respectively: "Yeah well she takes it out on me and, which I think is pretty normal"; "When he got angry and that was okay because I thought, well, 'that's normal.'" The person with cancer was thus exonerated from behaviors which would normally not have been accepted. Melanie described the "mood swings" of her husband with prostate cancer as analogous to a woman with premenstrual syndrome, which functioned to absolve him from responsibility, because he is "not really in control of it." She told us that her husband would get angry at her for no reason, which meant that she had to "walk a fine line of when do you actually snap and get angry back or just think, just bite your tongue and don't cause a big argument and that sort of thing."

Melanie's account suggests she did not always repress her anger. If she felt her husband had crossed a line and had become "abusive," she did "snap and get angry back." This response suggests a conscious decision to stop self-silencing and let anger out. In other accounts, carers talked of expressing anger or irritation in a less controlled way, such as when Naomi described "losing patience" with her husband who had brain cancer: "You sort of try and be patient but then you lose patience. It was always over the children, all our issues were always over the children." A number of carers told us they felt guilty if they failed to self-silence anger. Alan described his experience of caring for his mother with colorectal cancer thus: "So you get angry, you start to yell at her and at the same time, after a few minutes you realize, 'why did I do that?,' and you kind of like regret it . . . I felt guilty that I did it." However, Alan went on to justify his behavior by saying, "but at the same time I realised I shouldn't have felt guilty 'cause I had to let go of my emotion." Other carers talked of justifying their anger to the person with cancer in an attempt to assuage guilt, as is evidenced by the account of David, whose wife had breast cancer: "Sometimes when you become angry you tend to feel guilty and not really good afterwards . . . and just have to comfort her or to explain to her that I'm not really good the way I am and I've got my own feelings."

A number of participants reported that, when they openly expressed anger or irritation, the person with cancer would evoke feelings of guilt in an attempt to silence them. As Paul told us "sometimes I say 'you're being unreasonable.' And then her attitude would be, 'I'm being unreasonable, I'm the one with cancer, what's your problem.'" Similarly, Gay described her husband with brain cancer:

I still have to bear my husband's bad temper. He always uses one thing to speak against me, "I have no time left, not much time left so . . ." Because of that response from him, I have to suppress whatever my feelings are I have inside me.

The self-silencing of the carer was thus maintained within the relationship through the comments of the person with cancer.

Counternarrative: Open Expression of Carer Emotions

Self-silencing of carer needs or anger, accounts of guilt following the expression of anger, or patient refusal to listen to carer concerns were not universally found across all of the interviews. A number of participants, 26% of the interview sample, gave accounts of openly expressing their feelings to the person with cancer and of this openness being a positive experience within their relationship. For example, Coral told us how she broke her self-silencing with her husband, who had prostate cancer, some years ago. This breakthrough led to a pattern of open communication between the couple that they still enjoyed:

I remember a couple of years ago, hearing A talking to one of the children on the phone and he said "Oh Coral's fine, she's coping wonderfully well" and I never ever shout, I never swear but I came down the hall screaming at the top of my lungs: "I am not bloody fine, I am falling apart. How dare you, how dare you tell the children I am coping fine." Well that's the first he knew.

Some participants talked of having valued open communication in their relationship prior to cancer, which continued during their time as a carer, allowing their needs or concerns to be expressed. June said of her relationship with her husband with prostate cancer: "we just have a really good open communication . . . an ability to have really good open communication so nothing is taboo. We just say what's on our minds and that's worked out well for us. So it's good in that respect." Jenny gave a similar account of her relationship with her husband with brain cancer: "We always had really good communication before this happened and I think that's been the main thing, that we've really made an effort to keep that going." A number of participants positioned open communication as central to their ability to cope with cancer, as Marcus told us of caring for his wife with breast cancer:

We could talk to each other. We've always had a very open sort of thing. One of the main factors of our marriage or relationship is that we can communicate; we've got excellent communication between us. And because of that, we've had a very good marriage and because of the communication we were able to overcome all obstacles during her treatment and during her illness.

Conversely, there were accounts of couples having to learn to talk openly to each other since the advent of cancer, which was described as being of benefit to the relationship. As Myra, caring for her husband with lung cancer, told us: "after this illness we have more time to sit together to talk to each other and to share our feelings. So we listen to the other, we listen to each other. So actually our relationship becomes better." Similarly Paul told us, "E and I, we've sorted out a few issues over the last month or six weeks or

whatever. In some ways I feel closer to E . . . than I have been for some time.”

DISCUSSION

Our study has provided further insight into the consequences of avoidant patterns of communication between people with cancer and their partners, extending the analysis to include nonpartner carers, across a broad range of cancer types. At the same time, we have demonstrated the utility of self-silencing theory for providing a partial explanation for cancer carers' depression and anxiety, and we have addressed the call for further examination of reasons for gender differences in self-silencing behavior.

The quantitative analysis established that the cancer carers who took part in our study were self-silencing at levels comparable to, or higher than, populations of adults outside the context of cancer (Cramer & Thoms, 2003), and at the same time, they were reporting levels of anxiety and depression higher than population norms for Australia (Australian Bureau of Statistics, 2008; Janda et al., 2007). These findings add to the now extensive body of research that has demonstrated that informal cancer carers experience high levels of anxiety and depression (Hagedoorn et al., 2000), with anxiety being found to be more prevalent than depression in the present study. The association between self-silencing and depression found in both a cancer (Kayser et al., 1999) and noncancer context (Duarte & Thompson, 1999; Gratch et al., 1995; Jack & Dill, 1992; Thompson, 1995; Uebelacker, Courtnage, & Whisman, 2003; Whiffen et al., 2007) has been confirmed, and the association between self-silencing and anxiety established. Women carers reported higher levels of depression and anxiety than men, confirming previous research on gender differences in cancer carer distress (Hagedoorn et al., 2008). This finding is in line with general population norms, where women consistently report higher rates of depression and anxiety than men (Bebbington, 1996; Kuehner, 2003). However, although Global Self Silencing on the STSS was positively correlated with depression and anxiety, men scored higher than women on Global Self-Silencing and on two facets of self silencing: putting the needs of others before the self (Care as Self Sacrifice) and not expressing their feelings when to do so would cause disagreement (Silencing the Self), a pattern also reported in previous research (Cramer & Thoms, 2003; Duarte & Thompson, 1999; Gratch et al., 1995; Page & Stevens, 1996; Thompson, 1995; Whiffen et al., 2007).

One explanation for this apparent paradox is that the aspects of self-silencing on which men rated highly were not strongly associated with depression and anxiety. In the present study, Care as Self Sacrifice was not correlated with depression or anxiety at all, which confirms the findings of Whiffen et al. (2007), who examined self-silencing and marital conflict in a community sample of adult couples. The correlation between Silencing the Self and depression

was also weaker than that found on the other subscales, as reported by previous research (Duarte & Thompson, 1999; Whiffen et al., 2007), with no association found with Silencing the Self and anxiety for men. Thus, men may report more self-silencing behaviors, but these behaviors are at best weakly associated with depression and not associated with anxiety. There is also evidence that self-silencing may be functioning differently for men and women, as is evidenced by the finding that the Care as Self-Sacrifice and Divided Self subscales were intercorrelated for women, but not for men, as previously reported by Duarte and Thompson (1999). This pattern suggests that women who prioritize the needs of others are putting forward a compliant outer self, while their inner self grows angry and hostile, and as a result, women experience a loss of self—a pattern not seen for men. This is because a woman's sense of self is conceptualized as “being in relation” (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Miller, 1986), with mutual connectedness being central to identity and well-being, and the absence of empathic connectedness experienced as a failure of the self that can result in a state of loss and depression (Kaplan, 1986). The qualitative analysis of in-depth interviews acts to provide further insight into these gender differences in self-silencing behavior in the specific context of caring for a person with cancer.

Both male and female participants positioned their own needs as secondary to those of the person with cancer, and as a result, suppressed those needs. This pattern of behavior is comparable to Jack's (1991) description of Care as Self-Sacrifice. However, in the present study it does not appear to be primarily motivated by a desire to secure attachments, born out of feelings of insecurity, as Jack (1991) and others (Duarte & Thompson, 1999; Thompson, 1995) suggest. Rather, it is positioned by participants as a context-specific choice to prioritize the needs of the person with cancer, a sacrifice that is made willingly as part of the cancer caring role. A socially sanctioned and valued justification was therefore provided for this self-sacrifice, which may account for this facet of self-silencing not being associated with depression. This speculation is supported by participants' accounts of self-sacrifice being a privilege, confirming previous reports that cancer caring is experienced as a “gift” (Grbich, Parker, & Maddocks, 2001, p. 33) or an “honour” (Sinding, 2003, p. 157). This particular form of self-sacrifice may also reflect patterns of behavior which become normalized in long-term relationships without negative psychological consequences, as is suggested by the findings of Whiffen et al. (2007).

Accounts of silencing feelings in order to cope, often associated with awareness of the evaluation of others, were much more common in women than in men. This difference may reflect the “self-policing” (Foucault, 1979) that is central to women's gendered role and linked to constructions of idealized femininity, in particular to the positioning of women as “natural” carers (O'Grady, 2005; Seigfried, 1989) or better suited to the caring role than men (Collins

& Jones, 1997). Michel Foucault (1979) described self-policing as the modern replacement for external, authoritarian, methods of surveillance and social control, where discipline is instilled within, and punishment, if we waver from the norm, self-induced. As Gordon (1980, p. 155) comments: "There is no need for arms, physical violence, material constraints. Just a gaze. An inspecting gaze, a gaze which each individual under its weight will end by interiorizing to the point that he is his own overseer, each individual thus exercising this surveillance over, and against, himself." Indeed, it has been argued that self-policing practices are now so ingrained in the Western psyche that they are taken for granted, scarcely visible to conscious awareness, making them all the more effective as a means of social regulation (Foucault, 1979). Gendered self-policing practices can lead to self-renunciation and overresponsibility on the part of women, as they attempt to emulate an idealized version of femininity (Strickling, 1988; Ussher, 2004). This is evidenced by previous research on women cancer carers who were found to position themselves as all-encompassing expert carers, leading to overresponsibility and self-sacrifice, in contrast to men carers who positioned caring as a competency task, leading to feelings of self-mastery (Ussher & Sandoval, 2008). This gender difference in self-policing partly results from external factors, as women carers generally have higher expectations placed upon them (Soothill et al., 2003). However, it is also associated with women internalizing the notion of the "caring self," and judging themselves as failures if they cannot provide the level of care expected (O'Grady, 2005; Ussher, 2006). Forssen, Carlstedt, and Mortberg (2005), in their research on elderly women carers in Sweden, have described this process as "compulsive sensitivity," an inner demand to take responsibility and put the needs of others before the self, which can lead to distress, which is then blamed on the self. It has been suggested that the higher rates of depression reported by women cancer carers could be explained by women having to live up to these high standards of caring and coping, in contrast to men carers who perform a role which is not expected of them, and thus men experience a greater sense of reward as a result (Hagedoorn et al., 2000). Supporting this view, it has been reported that feelings of failure in relation to informal cancer care are associated with distress in women, but not in men (Hagedoorn, Sanderman, Buunk, & Wobbles, 2002).

Accounts of male carers, or male patients, never expressing needs or feelings, suppressing vulnerability because it is unmanly, or putting up a positive front draw on hegemonic discourses of masculinity wherein emotional expression is positioned as weakness (Batty, 2006; Edley & Wetherell, 1995). Thus, boys are socialized to be strong and courageous and to suppress emotion or vulnerability in the face of stress (Felsten, 1998), with self-silencing occurring in reaction to these social norms (Duarte & Thompson, 1999). Men may also not develop the emotional vocabulary to communicate relational and emotional needs, and thus self-silencing

becomes their default option (Gratch et al., 1995). This pattern stands in contrast to women, who generally do have the emotional vocabulary to express their needs, but who self-silence to achieve connectedness with others (Kaplan, 1986) or to live up to culturally constructed ideals of coping and competent femininity (Ussher, 2004) as discussed above. This speculation provides some explanation for the finding that the Care as Self-Sacrifice and Divided Self subscales were intercorrelated for women, but not for men, in the present study because self-silencing is normalized and expected for men and thus does not lead to anger or loss of self. The inclusion of an "Autonomy/ Concealment" factor on the STSS for men (Remen et al., 2002), reflecting a tendency for self-sufficiency and concealment of potentially undesirable aspects of the self from one's partner, has resonance with men's accounts of self-silencing to conceal vulnerability in the present study, and it is a coping strategy also reported in previous research with men cancer carers (Lethborg, Kissane, & Burns, 2003).

These findings add further confirmation to the suggestion that men and women self-silence for different reasons and with different consequences for their mental health. The suggestion that women and men respond differentially to life events affecting others (Maciejewski, Prigerson, & Mazure, 2001), described as "network events" (Kessler & McLeod, 1984, p. 620), may also be implicated in gender differences in self-silencing. For example, women have been found to report more life events concerning crises or illnesses affecting significant others or related to difficulties in getting along with others (Dalgard et al., 2006; Kendler, Thornton, & Prescott, 2001). At the same time, although men and women have been found to be equally likely to remember their own life events, men have been reported to be less likely than women to remember life events affecting significant others, leading to the suggestion that men may avoid depression through "blocking out," or not attending to, network events (Nazroo, Edwards, & Brown, 1997; Turner & Avison, 1989). Women's greater response to network events has been attributed to their more significant involvement in the lives of those around them (Dalgard et al., 2006; Kessler & McLeod, 1984), which produces a greater sense of responsibility (Nazroo et al., 1997; O'Grady, 2005), representing a "cost of caring" (Kessler, McLeod, & Wethington, 1985) that leads to elevated levels of depression because of the salience of these events to women's role identity (Nazroo, Edwards, & Brown, 1998).

Accounts of carers silencing anger toward the person with cancer to avoid conflict are analogous to Jack's (1991, 2001) description of Silencing the Self. Both men and women carers described consciously suppressing anger that they would normally express because they positioned the person with cancer as vulnerable, with any difficult or argumentative behavior attributed to the illness, which functioned to excuse it. In the statistical analysis, Silencing the Self was significantly associated with depression, confirming previous research (Duarte & Thompson, 1999; Jack,

2001; Thompson, 1995), and participant accounts in the interviews bear testimony to the personal cost of silently bearing the brunt of patients' anger or frustration and of feeling guilty if the carer expressed anger. Accounts of the person with cancer eliciting guilt if the carer expressed anger demonstrate that self-silencing occurs in the context of a relational interaction, which is influenced by the responses of significant others. This conclusion also confirms that cancer is, as Kayser et al. (2007) described it, a "we-disease," that is, a dyadic interaction with both parties in the carer-patient dyad acting to influence each other's attempts to process and cope with the illness (Badr & Carmack Taylor, 2006).

The majority of participants who gave accounts of suppressed anger were partners of the person with cancer who described positioning the person with cancer as a "patient" rather than a partner. This shift in positioning in the context of cancer can have a significant impact on the relationship, leading to reductions in intimacy and sexuality (Gilbert, Ussher, & Perz, 2010; Hawkins et al., 2009), which in turn can lead to or exacerbate distress (Foy & Rose, 2001). Previous research has reported that the avoidance of communication results in lower relationship satisfaction for couples living with cancer (Manne et al., 2006; Ptacek, Pierce, & Ptacek, 2002). The shift to a carer-patient positioning may be one explanation for this finding. Although both women and men talked of expressing anger, it was an experience more commonly reported by men. This difference may be because anger is positioned as unacceptable for women within idealized constructions of femininity (Ussher, 2006), resulting in women carers being less likely to describe their emotional reactions in such a manner within an interview. Men were also more likely to give accounts of assuaging guilt through justifying their anger, which may reflect the positioning of anger as a normal or expected aspect of masculinity (Edley & Wetherell, 1995). However, a weakness of the present study was that anger was not assessed directly. This extension would be a fruitful avenue for exploration in future research.

Accounts in the present study of carers continuing good communication, or experiencing improved communication following cancer, and of experiencing a closer relationship with the person with cancer as a result stand as testimony to the importance of addressing self-silencing through psychosocial interventions in the field of cancer (Badr & Taylor, 2008). Previous researchers have also reported that open communication in the context of cancer can function to bring couples closer (Dorval et al., 2005), resulting in a more intimate relationship (Manne, Ostroff, Rini et al., 2004) or emotional growth (Manne, Ostroff, Winkel et al., 2004). The present study suggests that these outcomes may also result for noncouple carer-patient dyads.

One of the limitations of the present study is that the focus was only on carers, and thus self-silencing and psychological well-being on the part of the person with cancer, or the interaction between carer and patient communication,

has not been assessed. Future research on self-silencing in the context of cancer should look at both partners in the carer-patient dyad and examine a broader range of communication strategies in addition to self-silencing.

However, our study also had a number of strengths. The mixed-method design allowed the magnitude of self-silencing and psychological well-being to be assessed using standardized questionnaires and the gendered nature of self-silencing in the cancer caring context to be explored using qualitative methods. The focus on gender adds a new perspective to research on communication in couples facing cancer because previous research has not systematically examined gender as an issue. This is a significant oversight given the substantial body of research demonstrating differences in communication patterns between men and women in relationships, particularly in relation to dealing with stressful events (Gottman & Krokoff, 1989; Heavey, Layne, & Christensen, 1993). Further research is needed to explore these gender similarities and differences more fully. The nature of the participant group in the present study is also a strength. The relatively large sample size as well as the broad range of cancer types and stages addressed the call for research on gender differences in carer well-being in areas other than breast and prostate cancer (Hagedoorn et al., 2008), and the inclusion of nonpartner carers extends previous research on communication in heterosexual couples to other forms of cancer carer-patient dyads. Finally, the study adopted a theoretical model, self-silencing theory, which provides insight into reasons for both cancer carer depression and gender differences in carer distress. The finding that men report higher levels of self-silencing, but women report higher levels of depression and anxiety can be partly explained through the different meaning self-silencing appears to have for women and men. However, self-silencing only accounted for a small proportion of the variance in predicting depression and anxiety, and thus factors other than self-silencing are also influential in producing cancer carer distress and women's propensity to report more distress than men. Future research should examine the relationship of such factors within a multivariate design, which would allow for the potential moderators and/or mediators of the association of self-silencing and cancer distress to be explored.

In conclusion, all of the participants in the present study had positive intentions in suppressing their own emotional needs or anger—the desire to prioritize the needs of the person with cancer or to protect her from burden or conflict, paralleling the findings of previous research on protective buffering or avoidance of emotional discussion in couples living with cancer (Badr & Carmack Taylor, 2006; Kayser et al., 2007). However, the significant association of self-silencing with depression and anxiety confirms that it is not an adaptive behavior for the carer, supporting previous reports that avoidance of emotional discussion in couples living with cancer is detrimental to coping and to mental health (Kayser et al., 2007; Manne et al., 2006; Skerrett,

1998). Because the well-being of informal carers has an impact on the well-being of people with cancer (Hodges, Humphris, & Macfarlane, 2005), this self-silencing of the carer is also an issue for the person with cancer.

Initial submission: April 28, 2009

Initial acceptance: November 20, 2009

Final acceptance: December 18, 2009

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