Qualitative Health Research
1–12
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DOI: 10.1177/1049732315579177
qhr.sagepub.com

Shame Experiences Underlying Depression of Adult Turkish Women

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Abstract

Shame is a major component of many mental health problems and affects symptoms, coping styles, remission, and therapeutic ruptures. There are few qualitative studies aimed at understanding shame and its role for patients diagnosed with depression. In this research, we explored the origins of shame, and the coping strategies that patients diagnosed with depression employ to cope with shame. This qualitative research aimed at an in-depth analysis of shame experiences of adult women who had been diagnosed with depression and treated with cognitive behavioral psychotherapy in a Women Health Center in Turkey. Purposive sampling yielded nine high shame prone adult women who were married and had children. Four semi-structured interviews were conducted with each of the nine participants, and 36 semi-structured interviews were analyzed by Interpretative Phenomenological Analysis. According to the results of the analysis, four themes emerged. These were "substitution of rage for the feeling of shame and unworthiness," "perfection struggle to overcompensate the belief of being inadequate," "feeling shame for their own body and sexual acts," and "need for individuation." The results were interpreted by considering the social context and culture of Turkey, and the clinical implications were discussed.

Keywords

Depression; shame; rage; adult women; interpretative phenomenological analysis; qualitative methodology

Shame is an overwhelming feeling related to interpersonal problems and psychopathology (Fergus, Valentiner, McGrath, & Jencius, 2010), many emotional disorders (Tantam, 1998), and depression (Andrews & Hunter, 1997; Danielsson, Bengs, Samuelsson, & Johansson, 2011; Tangney, Wagner, & Gramzow, 1992). When early memories of shame and lack of safety and warmth are internalized, vulnerability to depression increases (Matos, Pinto-Gouveia, & Costa, 2013). The attributional theory of depression (Gotlib & Abramson, 1999) proposes that depression and helplessness are related to shame, which has internal, global, and stable attributions for bad outcomes (Gotlib & Abramson, 1999; Tangney, Burggraf, & Wagner, 1995).

In psychotherapy group interventions, it was observed that concealed shame revealed feelings of self-directed anger with depression (Montgomery, 2006). Parallel to that, based on her transcripts of psychotherapy sessions, Lewis (1987) proposed that the principal component of depression is not anger or grief but rather unacknowledged shame (Lewis, 1971). According to Lewis (1971, 1987), acknowledgment of shame and encouraging patients to talk about shame are therapeutic. Scheff (2001) interviewed depressed men and staff of a psychiatry hospital in London for 7 months. During interviews, he observed that the self-blame and bodily and facial expressions of depressed patients were indicators of their unacknowledged shame. Scheff (2009) suggested to uncover shame after establishing secure bonds with the patients as a social–emotional therapy for depression. In another study, the relationship between shame-proneness, depression, and non-disclosure of emotions was explored in 85 men and women who had received treatment for depression (Hook & Andrews, 2005). It was found that for the effectiveness of depression treatment, encouraging and facilitating the disclosure of shame symptoms and related behaviors had positive implications (Hook & Andrews, 2005). Hence, it is crucial to work with shame experiences and uncover hidden shame (Lewis, 1971; Matos, Pinto-Gouveia, & Costa, 2013; Tangney, Wagner, & Gramzow, 1992) not just for treatment of depression (Fergus et al., 2010; Hook & Andrews, 2005; Scheff, 2001, 2009) but also for treatment of several symptoms of anxiety disorders, specifically obsessive-compulsive,

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social phobia, and generalized anxiety disorder (Fergus et al., 2010).

To understand experiences of shame related to depression, the concept of shame and the features that distinguish it from guilt must be clarified. Shame is a feeling of worthlessness and weakness (Gilbert & Procter, 2006; Morrison, 1999) and involves self-criticism and blaming one's character in a stable maladaptive way (Gilbert, 1998; Nathanson, 1992; Tangney & Dearing, 2002). In shame, the entire self is in contempt and defected (Lewis, 1971), which differentiates it from guilt as guilt is a feeling of remorse and regret about one's behavior and not about the entire self (Lewis, 1971). While shame leads the self to hide and disappear (Lewis, 1971), regret and remorse of guilt motivate reparative actions (Hoffman, 1982; Tangney, Wagner, Hill-Barlow, Marschall, & Gramzow, 1996). Therefore, shame, but not shame-free guilt, has a unique effect on depression (Tangney, Wagner, & Gramzow, 1992) because the internal, global, and stable attributions cause shame to be related to depression (Tangney et al., 1995).

The way in which one copes with or defends against shame is an important aspect of the experience of shame (Elison, Lennon, & Pulos, 2006). Lewis (1987) developed the concept of "bypassed shame" for unacknowledged shame as an attempt to distance the self from shame through repression or emotional substitution. Shame may be substituted by guilt, sadness, anger, or rage to overcome the pain of shame. These substitute emotions help the self to become more comfortable rather than to experience shame. When shame is acknowledged, coping strategies are used to regulate shame (Lewis, 1995). Prevention, escape, and aggression are among the maladaptive coping strategies proposed by Schoenleber and Berenbaum (2012). Prevention is used to restrain situations that will trigger shame by shame forecasting. Another type of shame regulation strategy, escape, is used when shame is triggered. It is used to distract attention from personal flaws. When shame is evoked in an ongoing situation, social withdrawal is used to reduce shame as an escape strategy. Aggression is shame regulation by directing anger at the self (e.g., physical self-harm) or others (e.g., verbal aggression; Schoenleber & Berenbaum, 2012). The defenses as well as maladaptive coping strategies make shame harder to define and disclose (Lewis, 1971; Nathanson, 1992), so it is important to understand these strategies to conceptualize shame better.

When shame is acknowledged, there may also be reluctance to disclose shame because of the fear of judgment and other negative interpersonal responses by others (Macdonald & Morley, 2001). However, in research settings with interview studies, people were found to be willing to disclose shame (Andrews & Hunter, 1997; Macdonald, 1998; Macdonald, Duncan, Morley, & Gladwell, 1997) when they were asked directly.

Qualitative research is preferred to study ineffability of emotions (Cromby, 2012) as it allows a deeper, contextualized understanding of emotions compared with quantitative research (Cromby, 2012; Harper, 2008). Moreover, qualitative research gives the opportunity to take into account the researcher's own emotional responses evoked during interviews to interpret the emotions of respondents (Hubbard, Backett-Milburn, & Kemmer, 2001). Therefore, qualitative research may be preferred when it is difficult to define and differentiate shame from other emotions and to enhance shame disclosure.

The literature includes qualitative studies of shame related to many health problems as eating disorders (Røtveit, Åström, & Severinsson, 2009), childhood sexual abuse (Dorahy & Clearwater, 2012), AIDS and stigma (Skinta, Brandrett, Schenk, Wells, & Dilley, 2014), resilience (Van Vliet, 2008), abusive relationships (Enander, 2010), and violence (Brown, 2004). These qualitative studies reveal how women handle and cope with shame.

Very few qualitative studies aimed at understanding how shame is experienced by women in relation to depression. To understand the relation of gender with depression and shame, Danielsson et al. (2011) examined the impact of gender on depression and found that shame was a strong overwhelming feeling related to depression for women. Another qualitative study was conducted with patients diagnosed with depression, which uncovered that women verbalized emotional distress more than men and that men talked more easily about physical distress related to depression (Danielsson & Johansson, 2005). Men had a tendency to externalize the cause, whereas women mostly blamed themselves and their personality (Danielsson, Bengs, Lehti, Hammarstrom, & Johansson, 2009). The difference of the gendered expressions of depression made us wonder about how women in our culture experience shame in relation to depression. Our research aimed at a phenomenological analysis of shame in adult women who were diagnosed with depression. To this purpose, the following question was asked: What are the origins of shame for high shame prone women who are diagnosed with depression? The defenses as well as maladaptive coping strategies make shame harder to define and disclose (Lewis, 1971; Nathanson, 1992), so it is important to understand these strategies to conceptualize shame better. Therefore, we tried to understand which coping strategies are used by these women.

Methodological Background

Qualitative methodology allows to develop an idiographic understanding of patients in health care and gives chance for health care professionals to understand lived

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experiences of patients (Biggerstaff & Thompson, 2008). When affect cannot be expressed in words and cannot be expressed in self-report data, it may be analyzed through qualitative clinical research, and interpretative phenomenological analysis (IPA) with its phenomenological nature can reveal the ineffability of the embodied experience (Cromby, 2012). IPA was chosen as a qualitative methodology to analyze shame, to facilitate self-disclosure with its in-depth interviews as IPA aims to explore participants' personally lived experiences in detail, and to understand how the participants make sense of that experience (Smith, 1996, 2004).

IPA was seen as the most appropriate methodology for this study as it is grounded within hermeneutics (Smith & Eatough, 2007). IPA gives the researcher a central role in making sense of and interpreting the personal experience of participants (Smith, 2004). Interpreting the interpretative subjects (Alvesson & Skölberg, 2009) is an important characteristic of IPA. We believed the double hermeneutic characteristic of IPA can help us understand and conceptualize shame better. Last, IPA seemed useful as it gives the opportunity to understand shame from a socio-cultural perspective with its emphasis on studying the person-in-context (Larkin, Watts, & Clifton, 2006).

Method

Participants and Sampling Method

A purposive sampling process consistent with IPA guidelines (Smith & Osborn, 2003) was used, and a homogeneous sample was formed based on six factors: diagnosis of depression, level of shame proneness, age range, marital status, same treatment history, and same socioeconomic status. We anticipated that each of these factors might contribute to the experience of shame.

The participants met the criteria for depression according to the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*; American Psychiatric Association, 1994) and high shame proneness, which was measured with the Test of Self-Conscious Affect–3 (TOSCA-3) Shame Proneness subscale (Motan, 2007; Tangney & Dearing, 2002). A distinction must be made between shame as an emotional state and shame-proneness, which refers to a tendency to make negative attributions about self (Tangney, 1996). Giner-Sorolla, Piazza, and Espinosa (2011) and Luyten, Fontaine, and Corveleyn (2002) stated that the TOSCA-3 Shame Proneness subscale measures shame as an appraisal of self-blame but not the emotional state or latent shame.

We have chosen the age range of 37 to 40 as this stage corresponds to early adult development (Levinson, 1997). At this stage, the women may feel stuck between the demands of society and family and their own ambitions and desires (Levinson, 1997). With a sample of married women who have children at this stage of adulthood (Levinson, 1997), we would have a chance of understanding shame experiences taking place in the family environment and shame experiences related to motherhood.

We wanted to form a cohesive and homogeneous sample and therefore chose participants who experienced a similar type of psychotherapy and who were of the same socioeconomic level. All participants had been treated with cognitive behavioral psychotherapy by the mental health team for at least 6 months. Based on women's answers to questions related to the socioeconomic index used in health research in Turkey (Nesanır & Eser, 2010), total household income, education of women, and the number of household members were elicited to assess their socioeconomic status. The women were from middle socioeconomic status.

Recruitment took place for 1 year, from 2011 till 2012, at the Women Health Center in Sarıyer, Istanbul. The authors had neither worked at that center nor had they met the participants before. The authors were working at the Middle East Technical University. The collaboration with the psychologists working at that center made it possible to recruit the participants. Before conducting interviews, participants were given information about the research process and were asked whether they would consider participating. Sample size was coherent with IPA guidelines (Smith & Osborn, 2003) and as IPA is an intensive and detailed analysis of cases, small sample sizes are preferred. Morse (1995) stated principles of saturation in qualitative research. Morse proposed that if the sample was more restrictive and clearly delineated, a faster saturation would be achieved. Based on these principles, we decided saturation was achieved when we obtained rich enough data for a comprehensive understanding of shame experiences for our cohesive sample. Limitations pertaining to representativeness are presented in the "Discussion" section.

Ethical approval for the study was secured from the Sarıyer municipality where the Women Health Center was located and from the Middle East Technical University ethical committee. Consent and information forms were administered. The participants were informed that confidentiality was respected and they could end the interview anytime they wanted.

Procedure

Data were collected through semi-structured interviews. There was a set of main research questions in the researcher's interview guide (see the appendix); however, the participants were encouraged to talk freely about important topics and express their emotions. The imagination

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technique (Young, Klosko, & Weishaar, 2003) was used to understand shame as shame is a relatively wordless state and may be experienced in the form of imagery (Lewis, 1971). The imagination technique is used to trigger emotions and to link emotions to childhood experiences in Schema Therapy (Young et al., 2003). When the women expressed a sense of worthlessness, shame, or anger about a current event during interview, I (Sarı) asked the women to close their eyes and imagine themselves at the time when they were a child and focus on that emotion. When an upsetting childhood image came, I wanted them to tell about the image and what they felt.

I met the willing participants who were referred by their psychologists at Women Health Center and conducted interviews with them. To examine shame in a deep and detailed way, and also to facilitate self-disclosure, I conducted four semi-structured interviews with each participant. The rapport between me and the participants enhanced shame disclosure as they stated that they felt they were approved and would not be judged because of what they said or felt during interviews. I met the participants once a week in the Women Health Center and interviewed them for 1 hour each week. Therefore, for one participant, data collection lasted 4 weeks for four separate interviews. To protect anonymity of the participants, their names have been changed.

Data Analysis

All interviews were audiotaped and transcribed and then analyzed according to the guidelines of Interpretative Phenomenological Analysis (Smith & Osborn, 2003; Smith, Osborn, & Jarman, 1999) by the two authors. The original transcripts were in Turkish; therefore, after analysis of the data, they were translated to English. IPA is idiographic, focusing on detailed examination of one case and then continuing to analyze the second case (Smith, 2004). Therefore, data analysis started after the first case interview. At the first level of analysis, a detailed idiographic case examination began by reading the transcripts of the first case and making annotations in the left margin. Recurrent themes were noted. Thus, the superordinate themes and subordinate themes were formed for the first case. The superordinate themes and subordinate themes were checked with the interview transcripts by the research team and a table was formed for the first case. The observations and notes of the researchers were also included in the analysis. Then, the same analysis was conducted for the second case, and this process was repeated for each case. Last cross-case comparisons were made to understand recurring themes and a table was formed for the four recurrent themes across nine cases. These four themes were substitution of rage for the feeling of shame and unworthiness, perfection struggle to overcompensate the belief of being inadequate, feeling shame for their own body and sexual acts, and need for individuation. The themes were supported by the examples of key sentences from the interview transcripts.

Trustworthiness of the Study

Qualitative research has standards of trustworthiness like subjectivity, reflexivity, adequacy of data, and adequacy of interpretation (Morrow, 2005). Qualitative research accepts the subjective nature of data and analytic processes, unlike quantitative research (Morrow, 2005). Subjectivity is not controlled or limited but used as data as it enhances the quality of the research (Patton, 2002). The researcher's own experience and understanding of the world affect the research process. Therefore, *researcher's reflexivity* is an important approach for the researcher to understand his or her own effect on the research (Patton, 2002).

Reflexivity is the process of becoming aware of the researcher's assumptions, predispositions, and personal experiences about research and making them overt to the self and others by *bracketing* (Fischer, 2009). Our theoretical framework was based on interpretative phenomenology (Heidegger, 1962) with hermeneutics. We used existential bracketing (Gearing, 2004). We set aside our suppositions and delineated our clinical interest as our research praxis for bracketing. By unbracketing during the reintegration stage (Gearing, 2004), we interpreted the themes by taking into account our clinical and theoretical orientations. The different clinical orientations allowed us to interpret the shame experiences of women better.

We will delineate our clinical interest and experience with shame as research praxis for bracketing. My (Sarı's) relationship with shame came from my clinical experience while I was conducting psychotherapy with women who suffered from psychological neglect and traumatic experiences before my doctorate study. At these times, I observed that guilt and shame were among the most difficult emotions women experienced related to traumatic experiences. My clinical orientation is cognitive behavioral and I am conducting Schema Therapy. I also have an interest in Self-Psychology. The second researcher's clinical orientation is analytic therapy. We conceptualized shame as a painful, hidden emotion originating from maladaptive childhood experiences with caregivers. Therefore, during this research process, data related to defense mechanisms, early family environment, and traumatic memories may have appeared to be more prominent to us.

Hellawell (2006) suggested that if a female interviews other females, there may be an element of insiderness on the gender dimension (Hellawell, 2006). To be transparent,

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I, Sarı, as a 34-year-old woman living in Turkey, felt the same feelings related to sexuality with the women in our study. I was also under pressure of social expectations and moral rules related to women's manners in Turkey. For example, talking about sexuality or having a boyfriend were undesirable things in my family. Most women in Turkey like me may feel ashamed of their sexuality during teenage years. That insiderness may be an opportunity for me to conceptualize and understand shame related to sexuality for these women.

Being aware of our past experiences and clinical orientations, we focused on understanding women's lives and shame and what women experienced from their own perspectives. By inductive emphasis, we tried to be flexible and open to the issues women expressed. For that purpose, I (first researcher) asked open-ended questions and conducted four interviews to enable the women to freely express themselves. One support for our inductive attitude is the emergence of new topics during interviews. Our interview questions did not involve questions related to sexuality or individuality. However, the women talked about the issues of "chaste wife and sexuality" and also the "individuality problem." These issues formed our two themes.

We also approached the research process reflexively by disclosing our emotions and using these in the analysis of the cases. I (first researcher) took notes about my emotions that were evoked during the interviews. The most prominent emotion I felt during interviews was worry related to the future. I am married and at a close age to the participants. I do not have a child. During interviews, my fears evoked related to becoming mother. I sometimes worried related to participants' guilt and had conflicting feelings related to becoming mother. Another powerful emotion I felt was grief. I felt grief and sometimes helpless for the intense shame and rage of women that evoked during interviews. That was an interaction of my emotions and women's. I used that interaction to understand and conceptualize shame experiences of women. For instance, when Ada felt unworthiness and shame about the event with her father during interview, she directed anger toward me. She said, "I don't care about these emotions, these do not affect me anymore." She had an angry tone of voice. She wanted to end the conversation. I felt helpless and worried, I could not talk and also felt angry. I noted these emotions in the reflexive diary. Then during data analysis, her anger against me and my emotions showed us that she used anger as a detachment strategy to overcome her vulnerable shamed self that evoked during the interview. Because of the detachment strategy and her rage, the people around her might feel helpless, worried, and angry as I felt during the interview. That formed the first theme of our study.

Another strategy for reflexivity is to consult a research team or peer debriefers (Elliott, Fischer, & Rennie, 1999). Our research team included the researchers, a supervisor, and a clinical psychologist. The research team checked the transcripts and reflexive diary and discussed the themes. All themes were audited by the research team, which made the research process transparent, and the direct quotations for the themes enhanced credibility. Moreover, a deep understanding of participants' meaning construction by taking into account culture and context improves the trustworthiness of a qualitative study (Morrow, 2005). Accordingly, we tried to understand the need of being a good mother and a chaste wife with reference to Turkish cultural ideals.

Results

We found four themes according to the results of Interpretative Phenomenological Analysis. The first theme was substitution of rage for the feeling of shame and unworthiness. The second theme was perfection struggle to overcompensate belief of being inadequate. The third theme was feeling shame for their own body and sexual acts, and the last theme was need for individuation.

Substitution of Rage for the Feeling of Unworthiness

Our first theme is substitution of rage for the feeling of shame and unworthiness, which also reflects the developmental origins of shame. The observed common developmental origins of shame stated by these women were criticizing, distant fathers or criticizing, over controlling perfectionist mothers who did not give unconditional approval and love to these women. The following extract belongs to Suzan, whose father humiliated her, blamed her for being inadequate, and shamed her during her childhood. The humiliation and withdrawal of love by her parent may be the developmental origin of shame that affected her sense of self and led to the feeling of shame and unworthiness. She directed rage toward all the men in her life to overcome the pain of unworthiness and shame. During the interview, I (Sarı) felt her anger toward her father and men and I also felt her need for approval, understanding, and also mirroring for her being.

> My father humiliated us . . . me and my sisters . . . told us that you are girl, you can't achieve that you can't do that . . . He discouraged us . . . We, all my sisters, felt anger at my father . . . We learned anger during childhood (her eyes filled with tears). He told us that he wished to have one more naughty boy instead of having daughters like us. I always felt unworthy and felt like there is something wrong with me. My father did not care about my emotions . . . (cries) . . . I hate my brother, we were subordinated to him . . . I hate men . . . (with rage) . . . My father, my brother, my husband.

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Ada told a memory about her father when she was asked to remember a shameful experience. She said her father always wanted more from her.

> Once I was driving with my father and my friend . . . my father was telling me my faults about driving. Then he said I couldn't drive as well as my friend . . . At that time I felt ashamed in front of my friend and also felt useless . . . This is the way my father treats me . . . He always did this . . . he wanted to motivate me, but I felt useless.

Ada was distant and tried to control her feelings after talking about that event. When I (first researcher) tried to talk about shame and feeling useless, she said "I don't care about these emotions, these do not affect me anymore." She had an angry tone of voice, she wanted to end the interview. Ada has been using this strategy of substituting anger for shame and unworthiness in her life. One instance for this was the difficult period she lived with her first child.

> A child is a leech, sucking everything (tone of voice and her facial expression involved disgust and rage). Sucks your life, hours, activities . . . When my first child was born, I felt very unworthy during that period . . . I was not working, waiting for my husband all day with no social life. I remember that I was feeling angry at my husband even if there was no reason.

Ada felt unworthy after giving birth and directed anger outward to her child and husband. When she felt unworthiness and shame during interview about the event with her father, she used the same strategy and directed anger toward me.

The women I interviewed not only directed rage and anger outward but also directed anger inward when they felt unworthy. Seda was unhappy with her husband. She believed that neither her husband nor her mother unconditionally loved her. She stated that she had a working mother who was ill, having many burdens. Her mother was so unhappy that Seda could not feel she was unconditionally loved. Seda only felt love when she was with her daughters.

> My dream was to be loved unconditionally as a wife and mother. I am a lovable mother but not a lovable wife. My husband does not care about me and he does not love me unconditionally . . . I feel unworthy sometimes . . . Because of that I feel unhappy and angry. Mainly I am angry at my self. If I believed in my self more, things would be different.

Perfection Struggle to Overcompensate the Belief of Being Inadequate

Our second theme describes how shame prone women strive to be perfect mothers to overcompensate shame related to the belief that they are inadequate mothers. When children of these women made a mistake, they blamed themselves and they wished to have perfect children. They criticized their own mothers for their parenting styles. Moreover, they were afraid of resembling their mothers. Therefore, they had no tolerance of making mistakes related to motherhood and criticized themselves severely when they did.

Meltem is a hardworking woman and a perfectionist in her job. Meltem had a dominant and rigid father who did not show much affection to his daughter. She also had a mother who worked hard and could not spend enough time with her. Meltem compared her daughter's childhood with her own childhood and said that she and her daughter could not spend much time together, either. She felt guilty for not spending enough time with her child and felt shame for being an inadequate mother. Meltem got annoyed by her daughter's faults as these faults provoked a feeling of shame about her motherhood. She wanted a perfect child who did not make mistakes to overcompensate her sense of shame about motherhood.

> When my daughter does not behave in an appropriate way, I blame myself and attribute this to my workload, my academic career. If I did not work so much and spent enough time with my daughter, maybe my daughter would be a perfect child as I wish . . . never get out of line, be a very hardworking girl. Of course she can make mistakes, but all mothers want these mistakes to be minimum. I wish my daughter would be very hardworking and I would be proud of that . . . But . . . when she forgets to do her homework, this changes her image for me . . . I feel shame, I blame myself that I should spare more time with my daughter, should pay more attention to her homework . . . I feel inadequate as a mother, feel guilty and full of remorse and more depressive. If I had spent more time with my daughter . . . maybe she would be more successful and everything would be better . . . Maybe she would become first in class.

Deniz had relationship problems with her husband. She stated that she felt shame and a sense of worthlessness during her marriage. After her husband's betrayal, they divorced. She allowed her husband to get their son's custody. She felt guilty about her motherhood and thought that she had made a mistake by divorcing and giving her son's custody. She remarried with her previous husband although she did not feel any emotional bond with him. Deniz had a very controlling critical mother, with whom she had a dependent relationship. Her mother usually made decisions about her life, and Deniz always felt being controlled by her and got angry at her. During the interviews, I observed that she introjected her mother's critical tone of voice. She was very self-critical, especially about her motherhood.

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> Since I have been an incompetent mother, had psychological problems, my son suffered in the past. Divorcing my husband and then remarrying him . . . I think I am the cause of the divorce . . . since in the past my mistakes affected my child, I wanted to do the best as a parent, wanted not to make any mistakes. I feel guilty deep down, so I believe I can't be . . . I am not a good mother . . . I made mistakes about it . . . I wished my child did the best in whatever he did . . . wished he could learn everything very easily . . . my son felt under pressure because of my expectations. My son is an anxious child maybe because of my perfectionist attitude.

The following extract is another example from Naz, who was trying to be a perfect mother. She wished to be different from her own mother, who had made mistakes.

> Because of the faults of my mother, I don't want to resemble my mother and I try to be a flawless mother . . . but I attribute my daughter's faults to myself . . . I must have done something wrong, and therefore, my child behaved in that way. I have to be a very good mother . . . My daughter shouldn't feel any distress because of me . . . However, I get angry easily at my daughter . . . I began to tell the same thing to my daughter my mother told me before. I panic . . . I resemble my mother more.

Feeling Shame for Their Own Body and Sexual Acts

The women in our study stated that they felt shame for their body during sexual acts. They did not want to appear naked when they were with their husbands. The first example is from Suzan who felt shame for her own body and avoided sex. She said that feeling shame about having sex and shame about her motherhood were similar feelings as in both she had a feeling of inadequacy.

> Since I do not like my body, I don't feel comfortable during sex and do not want to have sex. I think I am fat. My husband criticizes me and tells me that I am not beautiful, I am fat and I cannot manage to lose weight. At that moment I am ashamed of my body. I cannot feel comfortable since I am not self-confident about sex. Even if my husband did not criticize me, I would not love my body . . . It is about me. I should approve and love my body. It is a sense of feeling similar to what I felt about my motherhood. In both, I believe that I am inadequate. Even if I do the best, I feel inadequate

The following extract from Naz illustrates how these women feel guilty when they have sex with their husbands:

> When I married I felt guilty for having sex with my husband. I don't know why, it may be because of social pressure, in our culture, until you marry, having sex is forbidden. I was ashamed of my body, I thought I was ugly. I never turned on the lights when we had sex. I did not want my husband see my body naked, especially my breasts and sexual organ.

The next extract from Ada shows how the "good mother" role precluded "being a woman" and the desire for sexual acts.

> After I gave birth, I all lost my interest in sex for two years. Being a good mother . . . the stress of taking care of child exhausted me. My husband did not share my burden. The anxiety of being a good mother . . . I was breastfeeding my child, I was a mother, I suspended my desires for sexual activity. Taking care of my child became more important for me.

Seda also suppressed her sexual desires and felt how women are devalued and are ashamed in society because of their sexual desires.

> I am afraid of behaving sexually provocative to my husband . . . you know what I mean? To allure and show your sexual desire . . . to turn on your husband are so feminine behaviors. I should not behave like that. I haven't worn any underwear that was sexually stimulating . . . I am afraid of being a wanton. We grew up with the belief that being fond of sex, being a lustful woman is very bad, dishonorable. We learned that. I think sexual relation is a way of sharing love with your partner, but we were taught that a woman loving sex is to be ashamed.

These women also stated that they felt shame for their abdomen during pregnancy because it corporally showed they had a sexual life. Sexual activity was like a wrong behavior as they felt guilty and were afraid of being witnessed by others. Eda stated,

> After we married and had sex for the first time, we went to my parents' house. I was so ashamed that I wanted to disappear because they knew we had sex. When I was pregnant, as my abdomen got bigger, I felt a sense of shame since my mother and father knew that I had sex. When I was pregnant I felt guilty when we had sex. I supposed that my child in my abdomen felt that. I thought that with sexual pleasure I polluted my child's mind. I was a shameless woman for that.

Need for Individuation

The last theme was need for individuation. All the women in this study stated that they did not prioritize their own needs, desires, and feelings. One example for this was Suzan who was self-sacrificing toward her family and her friends. That attitude stemmed from the fear of rejection by people if she could not give what people wanted. However, she stated that she felt unworthy as she did not give priority to her needs. She directed anger at others and herself with self-contempt:

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> I realized that I got angry at myself this week. I did not spare any time for myself. When I do not care about myself but care about work, home, children, husband and friends . . . I feel angry at all of them. I feel tired . . . I feel like a loser, miserable . . . unworthy . . . depressive . . . I am mad at myself since I don't understand myself and make myself miserable . . . It is a feeling of worthlessness.

These women were bored with duties and doing something for others. There was a lack of joy in their lives. The following extract from Selin illustrates this:

> I do everything as a duty. I do not remember what makes me happy. I do what I do as a task and I can't be happy. I always care about others' wishes and do what others want, and feel unhappy . . . I need to understand what makes me happy, to understand what I really want.

Toward the end of their 30s, the women started to question what they wanted from life, and realized that they put individual needs behind socially imposed roles. Moreover, they understood that the mother and wife roles were not enough to satisfy them and make them happy. Ada stated,

> I am a woman, I shouldn't have a life of marriage only. In the past, I wanted to do everything with my husband and children, now I feel that I want to do something alone. My husband may think that I became selfish . . . I have a feeling of being independent . . . I think, probably, in time, living for others diminishes.

Meltem explained,

> In my 30s, marriage, having children, my job . . . I was anxious about doing everything right. Passing to your 40s, you understand that you lost yourself during this rush. I was a wife, a mother. They came first, I played second fiddle. Towards my 40s I turned to myself and rediscovered myself. At my 30s, social approval was more important. Towards my 40s, maybe because of the things I experienced, the illness, betrayal of my husband, I discovered the most important thing in life was living for the moment, understanding and being understood by others.

Discussion

In our study, we interviewed women diagnosed with depression and treated through cognitive behavioral therapy to understand their shame experiences and coping strategies. We analyzed the data through Interpretative Phenomenological Analysis and found four themes. Women felt shame mostly about their motherhood and strived to be perfect mothers. They also felt shame about their own body and sexual activity. They directed anger inward and outward to overcome the pain of shame. However, they felt guilt and even more depressive after these self-defeating strategies. While they tried to be good mothers and chaste wives, they ignored their needs as women.

The first theme of our study was substitution of rage for shame among depressive women. In the literature, shame proneness is found to be associated with anger arousal, blaming others, and indirect expressions of hostility (Tangney, Wagner, Fletcher, & Gramzov, 1992; Tangney et al., 1996). In our study, shame prone women directed anger outward to their children, their husband, or toward themselves. Consistent with this finding, Lewis (1971) stated that when shame is unacknowledged, emotion substitution may occur to overcome the pain of shame. However, unacknowledged shame followed by anger may lead to withdrawal and self-blame as indicatives of depression (Lewis, 1971). This theme also supports Nathanson's (1992) model of compass of shame. This model proposes that anger may be directed inward as a feeling of disgust and self-contempt or it may be directed outward to dissociate the self from shame. Anger may lead to a sense of assertiveness against passivity of shame (Morrison, 1999), but it does not change the state; moreover, it induces guilt (Lewis, 1995).

The women in our study strived to be good mothers while feeling deeply ashamed and defective (second theme). For depressive patients, internalized shame with maladaptive perfectionism leads to feelings of inadequacy which then result in a depressive mood (Ashby, Rice, & Martin, 2006). Similarly, in our study, the women whose defectiveness and shame originated from their own parents' unresponsive humiliating attitudes wished to be perfectly satisfying mothers. However, shame reenacted in their relationship with their children by their criticizing and perfectionistic attitudes toward their children. This may have sustained the feeling of shame and defectiveness as "bad parents" and their depressive mood. This supports Kaufman (1974), who stated that a parent feeling shame will unconsciously treat her children similarly to how her parents treated her, so that the shame pattern is repeated.

The emotional needs of women in our study were not met by their parents. They stated that they were not admired for their accomplishments or abilities and were not approved unconditionally by their parents during childhood. Moreover, their parents harshly criticized and humiliated them. Accordingly, shame memories with attachment figures and lack of safety and warmth make people vulnerable to experience depressive symptoms (Matos, Pinto-Gouveia, & Duarte, 2013). Aside from the women's extracts in our study, we can conceptualize "not meeting emotional needs by parents and trying to be perfect" from a Self-Psychology perspective. Kohut (1971) proposed that to form a healthy cohesive self, a child

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needs an empathically responding, approving parental figure, which is called the need for mirroring. He stated that when the mirroring and idealization needs of children are not satisfied, these children cannot develop a mature and cohesive self (Kohut, 1971) and a narcissistic injury may occur. Rothstein (1980) suggested that narcissistic injury may lead to a "pursuit for perfection." According to Tomkins (1987), perfectionism is used to maintain self-worth and may also be used to avoid shame (Sorotzkin, 1985). However, Kaufman (1974) proposed that perfectionism may confirm the sense of inadequacy and defectiveness. Therefore, to further interpret the results based on these propositions, women in our study may have had a need for perfection to maintain self-worth and avoid shame.

What does it mean to be a good mother for the women in our study? In our study, women described a good mother as a mother who can satisfy all the needs of her child and has a successful child with no interpersonal-, psychological-, and achievement-related problems. Similarly, in a qualitative study, the discourses of Turkish mothers were analyzed and it was found that good mothering discourse involved raising a smart, talented, superchild with the best education, and motherhood was experienced as a personal achievement (Dedeoglu, 2010). In another study of analysis of the motherhood concept in Turkey, it was observed that motherhood was idealized by doing the best, and doing the most correct thing to be a good role model for the children. This idealization of motherhood has also been expressed with the adjectives "blessed" and "holy" in our culture (Duman, 2007). However, all giving, self-sacrificing, and child-centered "good mother" beliefs cause feelings of guilt when these high standards are not achieved (Sutherland, 2006). Moreover, the motherhood myth of never being angry, always being attentive, and so on, was found to be guilt inductive as mothers believe that they are not doing enough (Rotkirch & Janhunen, 2009).

According to the third theme of our research, the women tried to fulfill an ideal of being a chaste wife who inhibits her sexual desires. In our study, women were ashamed of sex and believed they should not reveal their sexual desires to their partners. Supporting that, in a qualitative study, women diagnosed with depression also expressed feelings of shame mostly related to their body and sexuality (Danielsson et al., 2011). In patriarchal societies, men are expected to control the sexual behavior of women (Blackwood, 2000) and women are expected to be sexually unavailable (Ljungqvist, 2012). Parallel to our finding, chastity ideology and patriarchy control women's behavior in many cultures, including Korea (Shim, 2001), India (Yim & Mahalingam, 2006), the Mediterranean (Giovannini, 1987), and Morocco (Kadri, Mchichi Alami, & Berrada, 2010). In Turkey, female chastity, "namus," defines and controls the sexual behavior of women and family honor (Ilkkaracan, Seral, & Ilkkaracan, 2000), and women's lives as well as their position in the family and at work are affected by cultural control mechanisms (Erman, 2001).

The women in our study stated that they did not feel they were living their own lives. While fulfilling the roles of a good mother and chaste wife, shame prone women ignored their wishes, needs, and their individuality (fourth theme). Beşpınar (2010) observed that the personal and social identity of Turkish women was based on their roles as wives and mothers. Moreover, Turkish women were found to experience a conflict between their personal needs and family-centered gender roles (Erden-İmamoğlu, 2013). In Turkish culture, rather than individuality and independence, "dependency" is a desirable characteristic in interpersonal relationships (Kağıtçıbaşı & Ataca, 2005; Kağıtçıbaşı & Sunar, 1992), which may be related to why women in our study tried to conform to traditional roles and attach less importance to their individuality. Supporting this finding, Guendouzi (2006) revealed that the attempt to meet the social ideal of a perfect mother and a good wife resulted in feelings of guilt in working women. These women wanted to perform the roles of a good wife and mother successfully. However, as they delayed their personal needs, their sense of individuality was defeated.

There were limitations to our study. First of all, we cannot state that we uncovered the bypassed shame in women related to depression. Uncovering bypassed shame is a difficult process, which takes a long time because of the defenses. We can state that we gained an idea about defenses, coping strategies, and some original aspects of shame for these women. Second, these women had an experience of cognitive behavioral therapy for depression. That may have affected them as they gained an insight about feelings and questioned their needs. Therefore, they may have better expressed their feelings. They knew their need of individuation, and they had an idea about their problems. Therefore, this research cannot reflect the shame and coping strategies of women who did not experience a psychological treatment before. We cannot generalize findings from these individuals to cases of bypassed shame. Moreover, the criteria of middle socioeconomic status, living in Istanbul, being married, and being in early adulthood stage made our purposive sample more cohesive and restrictive, but limited its representativeness. This sample limits the transferability of the results to women living in rural areas of Turkey, with different socioeconomic status, different age range, or marital status. Therefore, we must be cautious in interpreting the results of the current study because of representational limitations. Despite these limitations, this study is the first phenomenological analysis of shame

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among depressive women in Turkey and thus may bring important insights.

Appendix

Sample questions for semi-structured interview:

1. What emotions do you feel when you are depressed?
2. Are there any emotions that you cannot cope with when you are depressed?
3. Have you ever felt shame recently in your daily life?
4. How did you give meaning to that experience?
5. How did you cope with that emotion?
6. Have you ever blamed yourself because of a fault you made?
7. How did you feel? Did any other emotion accompany?
8. Have you ever felt inadequate in any area in your daily life?
9. What was it about? Can you focus on the last experience you felt inadequate?
10. How did you feel? (For imagination) Focus on that emotion and close your eyes. Wait until anything from the past comes as an image to your mind with the same emotion. Can you describe that image to me?

Acknowledgment

We thank Elif Kuş Saillard for comments and contributions for this article.

Authors' Note

This article is based on the PhD thesis of Sevda Sarı.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

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