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Shame and depression: Psychological and cultural factors in a sample of Middle Eastern women

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Shame and Depression:

Psychological and Cultural Factors in a Sample of Middle Eastern Women

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Abstract

Shame is a self-conscious emotion that has been frequently tied to psychopathology;

however, despite its deep-rooted influence in the Arab culture, little research has been

conducted on its effect on the mental health of this population. Thus, this study

investigated the impact of shame proneness on depression severity in a sample of adult

Middle Eastern women living in the United States. The study also explored other factors

that are highly relevant for this population, including anger suppression, religiosity,

interdependent self construal, and Middle Eastern ethnic identity. Specifically, the study

investigated the role anger suppression plays in explaining the relationship between

shame and depression. Religiosity's possible impact on strengthening the relationships

between shame and anger suppression was also examined. Finally, interdependent self

construal and ethnic identity's effects on the relationship between shame and depression

were assessed. Participants included 203 adult women who self-identified as Middle

Eastern or Arab-American. Data were collected electronically, utilizing several self-

report measures. Results showed that shame proneness was a significant and positive

predictor of depression severity. Additionally, anger suppression was found to play a

significant role in explaining the relationship between shame and depression. Contrary to

the authors' prediction, degree of religiosity did not significantly strengthen the

relationship between shame and anger suppression and, instead was significantly and

negatively correlated with shame, anger suppression, and depression. Similarly,

interdependent self construal and ethnic identity did not significantly strengthen the

relationship between shame and depression severity. Clinical implications are discussed

in the context of risk and protective factors of mental health in Middle Eastern women.

Acknowledgment

Completing this dissertation has felt like the culmination of an intricate (and enormous) puzzle. This puzzle was built with the support, guidance, and love of many important people in my life. But before I thank those people, I must acknowledge the person who was ahead of me on LIU's admissions list, because if it were not for their decision to choose a different program, I would not be here today.

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CHAPTER I

Introduction

The Middle East has a unique and rich culture that is shaped by many norms, traditions, and strong religious beliefs. Collectivism, a unifying factor among Middle Eastern countries[1], has a profound influence on the structure and dynamics of Arab and Arab American families, including hierarchical parent-child roles, gender roles, and the importance of family honor (Erickson & Al-Timimi, 2001; Haboush & Alyan, 2013; Nassar-McMillan & Hakim-Larson, 2003). Women, especially, are expected to preserve the family honor by putting the needs and desires of their family above their own and by being modest and compliant (Ajrouch, 2004; Kulwicki, 2002). This interdependent nature of the Middle Eastern culture comes with its costs. For example, collectivists are expected to subordinate personal goals to group agendas, which has been found to lead to lower levels of personal happiness (Myers & Diener, 1995) and to hinder the achievement of self-actualization (Caldwell-Harris & Ayçiegi, 2006). Since individuals from the Middle East tend to define their identity in terms of their ingroup, transgressions may lead to real or imagined rejection and withdrawal of love, making this population especially prone to feelings of shame.

Shame is often understood as a reaction to criticism from others and is the result of the existence of a real or imagined audience who observe one's transgressions (Bierbrauer, 1992). Other conceptualizations of shame include attributing failures to an inherently defective self (Dost & Yagmurlu, 2008) and a global negative self-evaluation

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[1] The term Arab-American/Middle Eastern will be used interchangeably to refer to women who have ancestry in any of the Arab countries in the Middle East. Due to sociopolitical reasons, some individuals do not adopt the Arab label, even if their ancestry is in one of the Arab countries.

(Woien et al., 2003). Research on shame in the Middle East has found that failure to meet social obligations, giving in to sexual desires, and efforts of individuation are among the most common reasons for shame in that population (Sarı & Gençöz, 2016). In other words, both a desire to break away and individuate as well as failure to meet social obligations increase feelings of shame in Middle Easterners, especially women. This double-edged sword may explain the increased prevalence of shame in Middle Eastern women, compared to Westerners (Bierbrauer, 1992; Sarı & Gençöz, 2016).

Shame has been identified as a significant predictor of depression, suicidal ideation, adjustment disorders, exacerbated post-traumatic stress disorder, and Cluster C personality disorders (e.g., Andrews et al., 2010; Lee et al., 2001; Schoenleber & Berenbaum, 2010). Accordingly, the high prevalence of shame in the Middle East could explain the high rates of mental illness in that population. International psychological epidemiologists have amassed evidence to suggest that depressive disorders are becoming the leading contributors to mental illness in the Middle East (Eloul et al., 2009). In a recent study of older Egyptian and Jordanian individuals, 60 years and older, 84.2% of the participants reported a score of 16 and above on the Center of Epidemiologic Studies Depression Scale, indicating high depressive symptoms (Abu-Bader et al., 2017). Furthermore, depression is likely intensified due to the fact that mental illness is highly stigmatized among Middle Easterners, as it is perceived as an individual weakness or a possible cause of shame to one's own family (Al-Darmaki, 2003; Al-Krenawi, 2005; Hijiawi et al., 2013). Despite the robust link between shame and psychopathology, few empirical studies have investigated the interaction between shame and mental health issues in a Middle Eastern population. Moreover, due to the inconsistent data and high

stigma associated with mental illness in this population, depression should be assessed multidimensionally, capturing both symptoms and personality styles.

In addition to careful assessment of depressive presentations, factors that could impact the relationship between shame and depression should be explored. One factor that is of particular interest to the authors of this study is anger suppression. A strong link has been established between shame and the development of anger. Theorists have posited that acute painful feelings of shame lead to a sense of "humiliated fury" (Lewis, 1971; Scheff, 1987) that is often unconstructive, ranging from unexpressed, indirect aggression to displaced and active physical and verbal aggression (Tangney et al., 1996). Several studies indicate significant gender differences in the expression of anger, with higher rates of anger suppression among women compared with men (Cox et al., 2000). This tendency to suppress anger is likely even higher in Middle Eastern women who are often expected to be "respectful," "compliant," and "obedient" (Ajrocuh, 2004; Kulwicki, 2002). Additionally, anger suppression has been positively associated with depressive symptoms in non-clinical, undergraduate samples (Bridewell & Chang, 1997). Despite the robust link between shame and anger, and anger suppression and depression, no empirical study to date has investigated the link between shame, anger suppression, and depression and certainly not in a Middle Eastern population.

Further, a high degree of religiosity appears to strengthen the relationship between shame and anger suppression. Religion plays a major role in shaping the behaviors and thoughts of individuals from the Middle East (Bierbrauer, 1992). While religion has often been thought of as a protective factor against mental illness, there is research to suggest that this trend does not hold in highly religious individuals (Hutsebaut, 1996).

Instead, feelings of guilt, shame, and alienation have been found to be more elevated in religious individuals compared to their nonreligious counterparts (Reisner & Lawson, 1992). Moreover, a recent study found a link between extrinsic religious orientations and anger suppression (Beeksma, 2009). Since religion plays an integral role in the lives of individuals from the Middle East (Bierbrauer, 1992), more thorough research should investigate possible risk factors that may be associated with high religiosity in this population.

Finally, there are a number of factors that are likely to strengthen the relationship between shame and depression in Middle Easterners, two of which are interdependent self construal and ethnic identity. Interdependent self construal, which is closely related to collectivism, emphasizes the connectedness with others where the self becomes only meaningful in the larger context of social relationships (Markus & Kitayama, 1991). Individuals with a strong interdependent self construal tend to score higher on measures of shame proneness (Dean & Fles, 2016; Lutwak et al., 1998) and tend to suppress or avoid angry feelings in order to maintain social harmony (Markus & Kitayam, 1991). Relatedly, a stronger sense of Middle Eastern ethnic identity, which has been linked to higher levels of collectivism and interdependent self construal (Barry et al., 2000), is likely to reinforce the positive relationship between shame and depression.

This study aimed to investigate the relationship between shame and depression in Middle Eastern women. Specifically, the study first examined whether higher levels of shame proneness indeed lead to heightened severity of depression among Middle Eastern women. Further, the study examined whether anger suppression may partially explain the relationship between shame proneness and anger suppression in this population.

Finally, the study investigated the role of religiosity on anger suppression and the roles of interdependent self construal and Middle Eastern ethnic identity on depression. Specifically, the study predicted that participants with high shame proneness and who are highly religious would endorse significantly more anger suppression and more depression than participants with less religious. Moreover, the study predicted that participants with high levels of shame proneness and who report a high degree of interdependent self construal and a high degree of Middle Eastern ethnic identity, would endorse significantly higher severity of depression.

The review of the literature will first provide an overview of Middle Eastern culture, including a brief description of geographical locations, historical background, immigration trends. The emphasis on collectivistic tendencies in Middle Eastern culture will be discussed, and issues of gender roles and scarcity of data within that population will be reviewed. This review will then focus on the construct of shame proneness in Middle Eastern women. Specifically, the review will discuss the relationship between shame proneness and depression. Important factors that impact this relationship will be highlighted. Intrapsychic, societal, and cultural factors are discussed, including anger suppression, religiosity, self construal, and ethnic identity. Ultimately, this review aims to shed more light on important elements that explain and strengthen the relationship between shame proneness and depression in Middle Eastern women, a population where such data are extremely scarce.

CHAPTER II

Review of the Literature

Middle Eastern Culture

The Middle East is a geographical and cultural region that has been referred to as the "Cradle of Civilization." The region consists of 22 countries from South West Asia and North Africa (Amer & Hovey, 2007). Middle Eastern countries extend from Libya to Afghanistan (Mohit, 2001). However, other countries that are often included when studying Middle Eastern culture are Turkey, Morocco, Algeria, Libya, and Tunisia. While each country of this large and complex area of the world has its own distinct culture, the countries are tied together by a shared "culture area." This culture area has distinctive patterns of development from infancy to old age that were formed due to centuries of mixing nomadism, peasant agriculture, and urban commerce, in arid and semiarid lands (Gregg, 2005). Despite economic, social, and political differences across Middle Eastern countries, certain Bedouin traits seem to continue to exert behavioral influences on the majority of Arabs; this is true irrespective of educational level, economic status, political philosophy, and religion (Almaney, 1981). Middle Eastern countries share a strong adoption of Arab culture and religion in everyday life as well as many similar beliefs, including the importance of community (Haboush & Alya, 2013).

Arab Americans are comprised of diverse religious, ethnic, and racial backgrounds, as well as reasons for immigration (Amer & Hovey, 2007). On average, Arab Americans tend to have higher levels of education and income than other groups (Brittingham & de la Cruz, 2005). According to recent data, more than 41 percent of Arab Americans have bachelor's degrees or higher, and the majority are employed in

professional and managerial jobs (Brittingham & de la Cruz, 2005). Arab Americans live

in all 50 states, with the majority immigrating from Syria, Lebanon, Palestine, Iraq, and

Egypt (Zogby, 1990).

Collectivism. As a whole, countries from the Middle East are highly collectivistic

(e.g., Bierbrauer, 1992; Buda & Elsayed-Elkhouly, 1998; Erickson & Al-Timimi, 2001;

Grey et al., 2018). "Collectivistic cultures tend to be more concerned about the

consequences of one's behavior for ingroup members and to be more willing to sacrifice

personal interests for attainment of collective interests" (Leung, 1987, p.99). Due to this,

Middle Easterners often prioritize the welfare of their family over that of themselves

(Erickson & Al-Timimi, 2001; Nassar-McMillan & Hakim-Larson, 2003). Additionally,

individuals with more collectivistic tendencies tend to be allocentric (Triandis, 2001);

that is, they define themselves in terms of social entities. Collectivists are more likely to

base their identity on their social system and to be more emotionally dependent on their

institutions and organizations (Buda & Elsayed-Elkhouly, 1998). Due to the strong

internalization of their ingroup norms, individuals from collectivist cultures enjoy

conforming to what their ingroup expects of them. Additionally, because of the

interdependent nature of collectivism, individuals from such cultures often receive more

social support, have increased feelings of belonging, and are less likely to report feeling

lonely (Triandis et al., 1988; Triandis & Gelfand, 1998).

Collectivism and interdependence in Middle Eastern culture seem to have

stemmed from a need for survival (Joseph, 1996). This area of the world has endured and

continues to endure many invasions and wars. Thus, the earlier need for a nomadic

lifestyle and tribal communities seemed to ensure that individuals remained connected

and safe within their community. Interconnectedness persists to this day across different regions of the Middle East and different religious groups (Haboush & Alya, 2013). For example, in a study comparing Middle Eastern and Western businessmen and executive managers, individuals from the Middle East were found to rely heavily on personal contacts (Badawy, 1980). Strong families from the Middle East are seen as a source of physical, economic, and social protection (Haboush & Alya, 2013). Therefore, maintaining family unity has resulted in keeping the extended family intact as a physical and emotional unit. This is usually achieved through greater interdependence and emphasis on behavior that preserves the family honor (Haboush & Alya, 2013).

Despite the positive aspects of collectivism, there are known disadvantages that have a significant impact on overall mental health. Research suggests that collectivist and traditional cultures may create conditions that foster depression and anxiety (Caldwell-Harris & Ayçiegi, 2006). In fact, studies have shown that African children tend to suffer from more internalizing disorders compared with American children, which may be due to the African children's sensitivity to parents' high levels of control (Weissman, 1993). Other intrapsychic difficulties that are often associated with collectivistic tendencies include fewer opportunities to achieve self-actualization and a stronger likelihood to feel dependent. Additionally, research has shown lower levels of self-esteem, lower reports of subjective wellbeing (Caldwell-Harris & Ayçiegi, 2006), higher levels of experiential avoidance (Hayes, 2017), and lower levels of happiness (Myers & Diener, 1995).

Gender Roles. Countries from the Middle East and North Africa continue to perpetuate the engagement in firm gender roles. Traditional Arab families tend to be

patriarchal (Al-Krenawi & Graham, 2000; Erickson & AL-Timimi, 2001). Men are expected to be the "representatives" of the family (Mourad & Carolan, 2010) and are often the financial providers (Kulwicki, 2002). According to Islamic Sharia law, a husband is the head of a household, and obedience is a duty of a wife. The impact of Sharia law is especially evident in the challenges that women may face when pursuing higher education and employment opportunities. While women continue to have the right to seek an education and work outside the home, many believe that their maternal role should be their ultimate priority (Higgins, 1985; Uskul et al., 2012). Such expectations are likely to create feelings of shame in women who perceive their absence from home as "failing" their motherly duty.

Honor is the dominant value of the traditional social system in the Middle East and is expected to be maintained by the men in the family who are responsible for the "chastity" of the women (Fişek, 1993; Sunar & Aral, 1999). Men are taught that their reputation and masculinity is tied to the chastity of the women in the family (Haboush & Alya, 2013; Kulwicki, 2002). By the same token, women are expected to preserve family harmony through being modest and by placing elder members' desires and needs above their own (Ajrocuh, 2004; Kulwicki, 2002). And thus, daughters are taught that their behavior is a reflection of their family (Dwairy & Van Sickle, 1996). In traditional Middle Eastern families, premarital sex is considered a dishonor to the family and betrayal of the future husband. Virginity, chastity, and family reputation are the "gold standard" characteristics that a man searches for in a future wife (Hojat et al., 1999). Therefore, disobeying such expectations likely results in significant feelings of shame in women.

Differential treatment between sons and daughters persists (Britto, 2008; Mourad & Carolan, 2010), with daughters' sexuality and purity being of more significance (Haboush & Alya, 2013). For example, in a study conducted by Hojat et al. (1999), 97 Iranians living in Iran and 160 Iranian immigrants living in the United States were asked to complete a questionnaire measuring pre-marital and sexual attitudes. Results showed a difference between the attitudes of Iranian women living in Iran and their counterparts abroad. Women respondents residing in Iran were significantly more likely to endorse that premarital sex is acceptable for boys but not girls. All respondents, in Iran and America, confirmed the prevalence of a double standard in sex among Iranians (Hojat et al., 1999). Thus, again, Middle Eastern women are much more likely to experience feelings of shame when going against their cultures' expectations, compared with men.

Factors relating to the scarcity of data from Middle Easterners. Despite the growing number of Arab Americans in the U.S. (Brittingham & de la Cruz, 2005), little is known about this population's psychological functioning. This issue can be attributed to a number of factors. One technical factor is that Arab Americans/Middle Easterners living in the United States are labeled as Caucasian/White for the U.S. Census in terms of race (Brittingham & de la Cruz, 2005; Britto & Amer, 2007). This issue is problematic as it combines data from European/Western individuals and Arab/Middle Eastern individuals under one category despite the major cultural differences between the two races (Ajrouch, 2004; Erickson & Al-Timimi, 2001; Nassar-McMillian & Hakim-Larson, 2003).

Secondly, little is known about Middle Easterners' psychological functioning due to the high stigmatization of mental illness among this population (Coker, 2005). Mental

illness is highly stigmatized among Middle Easterners, as it is perceived as an individual weakness or a possible cause of shame to one's own family (Al-Darmaki, 2003; Al-Krenawi, 2005; Hijiawi et al., 2013). Due to the collectivist nature of Middle Eastern culture, social isolation resulting from mental illness stigmatization has been equated to death (Coker, 2005). Consequently, negative public beliefs and social stigma have led individuals and their families to conceal mental illness, or to delay or deny needed treatment (Maulik et al., 2011). In a review of barriers and promoters of treatment in the Middle East, results showed that a third of treatment barriers related to the cultural environment involved stigma (Gearing et al., 2015). Nevertheless, Arab Americans appear to be more willing to seek mental health treatment, compared to Arabs in the Middle East, which could be attributed to distress due to discrimination. Data showed a significant increase in reports of discrimination towards Arabs and individuals from the Middle East following the September 11th terrorist attack and the more recent terrorist attacks of the Islamic State (Abuelezam et al., 2017; Ajrouch, 2004). In a community study conducted in Ohio with Muslim Arab Americans, 10.4 percent reported receiving professional psychological services during the two years before the study (Khan, 2006). Similarly, another study of immigrant Arab Muslims also found that 9.6 percent of the sample admitted to seeking mental health services during the three years prior to the study (Aloud, 2004).

Finally, there is a significant issue of accessibility to mental health services in the Middle East. Barriers to mental health care in that region include a lack of education for primary health care providers regarding mental illness, scarcity of trained mental health specialists, and overall lack of resources in developing countries (Karamustafalioğlu,

2010). For example, in Egypt, there are approximately 500 psychiatrists, including those under training, 1 for every 130,000 citizens (Okasha, 1999). More recent figures suggested the number of psychiatrists both in Egypt and Iran to be approximately 1000 (Mohit, 2001). The accessibility factor, however, should not be an issue for Arab Americans living in the United States. Nevertheless, it is imperative that mental health providers serving Arab Americans are knowledgeable about Middle Eastern culture to tailor their interventions as necessary (Erickson & Al-Timimi, 2001; Haboush, 2007). For example, one aspect that is important for culturally sensitive treatment is a familiarity with the high tendency for shame proneness in Middle Eastern women, as will be indicated by the research cited below.

Shame

Shame is a self-conscious emotion that requires several developmentally advanced cognitive skills (Kim et al., 2011). Prerequisites for shame include self-awareness and a stable sense of self (Lewis & Brooks-Gunn, 1979), self-reflection (Kagan, 1981), and the internalization of standards and behavior (Stipek et al., 1992). Shame, among other self-conscious emotions, is essential for social survival (Kim et al., 2011). Such emotions are widely viewed as useful in the maintenance of social relationships and group living (Leary, 2007). Nevertheless, research findings have linked chronic shame to depression, anxiety, substance abuse, and interpersonal difficulties (Dearing & Tangney, 2011).

Shame in Psychoanalysis. Various theoretical models have conceptualized shame in different ways. Freud, for example, did not view shame as a subject in itself; instead, he perceived it as a reaction formation against sexually exhibitionistic impulses

(Tangney et al., 1992). He described shame in relation to sexual instincts (Freud, 1905), the exposure of sexual organs (1910), or as related to the need to conceal "genital deficiency" in women (Freud, 1936). However, although he failed to draw a direct connection between shame and ego-ideals, Freud (1914) introduced the idea of an agency of the mind that compares the ego to an ideal standard. He later developed this idea in *Group Psychology and the Analysis of the Ego* (1921), when he emphasized the positive aspects of the relationship between the ego and its ideal. Eventually, the connection between shame and ego ideals was more clearly made. Shame became to be defined as a failure to live up to ego ideal, occurring when there is a discrepancy between the actual self and the ideal self (Jacobson, 1964; Morrison, 1987). Different pathways seem to lead to the experience of either pride or shame. One theory posits that identification with the admired ego-ideal creates feelings of pride while failure to live up to an internalized admired imago stir feelings of shame (Lewis, 1971).

Phenomenologically, shame is experienced as a wish to hide and avoid exposure (Fenichel, 1941; Lewis, 1971). Such a wish to hide can be elicited from exposure of sexual organs (Freud, 1910), loss of control over emotional restraint and social pride (Jacobson, 1964), or a failure to achieve goals (Morrison, 1987). Irrespective of what elicits shame, the shameful feelings appear to stem from ego and superego functions (Rizzuto, 1991). The experience of the individual who is feeling ashamed is tied to a defective sense of self (Dost & Yagmurlu, 2008; Woien et al., 2003), one that is weak, abnormal, or less than others. Moreover, being associated with individuals who are found in shameful situations, for example, poverty or jail, may also bring a sense of shame upon an individual (Rizzuto, 1991). This connection appears to be related to the

sense of self in relation to others. Due to this, the shame experience cannot occur in the absence of an "other," whether the other is present or imagined (Schafer, 1968). Lewis (1971) theorized that shame involves the imagery of an explicit or implicit disapproving other. Thus, even when the person is alone, the scrutinizing-self imagines how it would be viewed to another person. This necessary element of an "other" draws the connection between shame and actual or internalized object relations, and thus to the ego and superego ideals as relating to the sense of self in the presence of the object (Rizzuto, 1991). Object relation theorists view shame in the context of internalized childhood experiences that encouraged the development of an ideal self.

Two types of shame have been discussed: signal shame and painful shame (Rizzuto, 1991). Signal shame is understood as a normative regulatory ego function which alerts the individual to the possibility of an actual experience of shame (Fenichel, 1941). Painful shame, on the other hand, results as a failure of signal shame to modulate the impact of internal or external humiliating circumstances that are unacceptable to the person's sense of self (Rizzuto, 1991). Pathological shame is a chronic and persistent painful shame. Theorists differ in their opinions regarding the cause of pathological shame. For instance, Kohut posited that pathological shame is caused due to abnormal development of narcissism, which is the result of parental failure to respond adequately to a child's exhibitionist needs (Kohut, 1972). Others believe that it stems from the self's sense of failure with respect to goals, relating it to feeling insufficient with respect to self-object (Morrison, 1987) or disturbed mother-child communication (Basch, 1976). Despite the difference in opinions, most theories emphasize the importance of early development and adequate communication with objects (Kernberg, 1984; Rizzuto, 1991).

Clinically relevant issues related to shame are discussed by many psychoanalytically oriented theorists and clinicians, with narcissism (Lewis, 1987; Morrison, 1983) and depression (Izard, 1972; Lewis, 1987) being at the forefront of such issues. A number of psychoanalytic researchers also discussed relevant sex differences relating to shame, narcissism, and depression. Women are suggested to be more likely to experience feelings of shame compared with men (Lewis, 1971). This can be explained through the emphasis women place on relationships, which in turn makes them more prone to shame. Moreover, several researchers have shown women to be more prone to depression than men (Radloff & Teri, 1986). An empirical study investigated sex differences between shame, guilt, narcissism, and depression (Wright et al., 1989). Participants were asked to complete the Adapted Shame/Guilt Scale (Hoblitzelle, 1982), the Self-Rating Depression Scale (Zung, 1965), and the Narcissistic Personality Inventory (Raskin & Hall, 1979). The study sample consisted of 100 college students: 62 female participants and 38 male participants. The results of the study showed that shame and narcissism were inversely related. Furthermore, male subjects were more likely to score higher on the measure of narcissism, while female subjects scored higher on the shame scale. Finally, the study also found that shame was significantly related to depression and that women scored significantly higher on the depression scale compared to men (Wright et al., 1989). This study highlighted the important sex differences in proneness to shame, as well as the pathology associated with shame in men compared with women. The study, however, did not explore factors that may be deriving such differences from a societal and cultural perspective. For example, analysis of shame reactions between

genders across multiple cultures would have significantly furthered the results of this study and would have allowed it to generalize over a broader population.

Contemporary Research on Shame. Lewis (1971) was one of the first psychologists to make a clear distinction between the emotions of shame and guilt. Her work focused on the differences in affective styles between shame and guilt and how they relate to the formation of psychological symptoms. Building on her work, Tangney continues to explore and clearly distinguish the effects of shame and guilt. She (1989) created the Test of Self Conscious Affect, a measure that aims to differentiate between guilt proneness and shame proneness. Shame is clearly delineated as an affect that concerns the entire self, while guilt is associated with a particular behavior (Tangney et al., 1992). Unlike guilt, where the individual experiences their transgression as relating to a specific event or action, in shame, the "bad thing" is experienced as a reflection of a "bad self" (Tangney et al., 1992). In other words, individuals feel shame for who they are and guilt for what they have done. Shame causes the individual to painfully scrutinize their entire self, which leads to a sense of shrinking and of being worthless and powerless. The sense of exposure associated with shame causes the ashamed person to feel the need to hide and disappear.

Like others before them, Tangney and colleagues found a strong link between shame proneness and psychological maladjustment (1992). Shame has been identified as a significant predictive component of depression, suicidal ideation, adjustment disorders, exacerbated post-traumatic stress disorder, and Cluster C personality disorders (e.g., Andrews et al., 2010; Dearing & Tangney, 2011; Lee et al., 2001; Schoenleber & Berenbaum, 2010). Moreover, shame is also implicated in cardiovascular disease due to

the physiological stress responses triggered by stress due to shame (Black & Garbutt, 2002). In a series of two studies, investigators examined whether shame proneness and guilt proneness were associated with a different cluster of symptoms, based on attributional style. Two-hundred-and-forty-five and two-hundred-and-thirty-four undergraduate students from a large East Coast university were enrolled in the two studies. Participants were asked to complete the Self-Conscious Affect and Attribution Inventory (Tangney et al., 1988), the Test of Self-Conscious Affect (Tangney et al., 1989), the Symptoms Checklist-90 (Derogatis et al., 1974), the Beck Depression Inventory (Beck & Beck, 1972), the State-Trait Anxiety Scale (Spielberger et al., 1970), and the Attributional Style Questionnaire (Seligman et al., 1979). The results failed to show a distinction between shame, guilt, and psychopathology as relating to attributional style. However, the study found a significant correlation between shame proneness and a host of psychological symptoms. While the study showed a relationship between shame proneness and depressogenic attributional style, the results indicated that the link between shame and depression was not solely due to attributional factors (Tangney et al., 1992). Guilt, on the other hand, was not found to be significantly related to psychopathology. A limitation of this study is that it was conducted among mostly Caucasian participants, 72% and 83%, respectively, which creates an issue of generalizability.

   Shame Across Culture. Cross-cultural analysis of shame has gained popularity in recent years (Lee, 1999). Researchers agree that shame is a universal human emotion that is evident in all known human cultures (Brown, 1991; Fessler, 2004; Tracy & Matsumoto, 2008). Researchers also agree that shame seems to universally stem from a sense of exposure to information that may reduce the value of the individual in the minds

of others (Gilbert & McGuire, 1998). Despite the universality of shame, people are not equally prone to shame (Tangney et al., 1992). Cross-cultural research suggests that entire nations vary in their proneness to shame (Sznycer et al., 2012). For example, Asian and South Asian cultures, such as Japanese and Indonesian, appear to be significantly more shame prone than Western cultures, such as European (Fessler, 2004). Additionally, several elements of shame, including the value ascribed to shame and the antecedent events that give rise to shame, seem to vary across cultures (Wong & Tsai, 2007).

A recent study on cross-cultural proneness of shame linked shame to the information threat theory (Sznycer et al., 2012). Specifically, the study posited that shame proneness is related to the ease of forming new relationships, the potential audience of devaluation, and one's current social value. These researchers theorized that the aforementioned variables vary from one culture to another, and thus shame proneness should vary accordingly. To test these hypotheses, data on shame proneness and relational mobility were collected from 88 participants from Japan, 87 from the United States, and 161 from the United Kingdom. Relational mobility, or the ease by which one can form new relationships, was measured for close relationships and distant ones. The study utilized an adapted version of the Personal Feelings Questionnaire-2 (Harder & Zalma, 1990) to measure shame proneness and the Relational Mobility Scale (Yuki et al., 2007) to measure the perceived opportunity to form new relationships in one's local environment. Results indicated that shame proneness was significantly higher among the Japanese participants compared with the U.K. and U.S. participants. The results were only significant for close relationships and not for strangers. The study also found that

relational mobility was lower in Japan compared with the U.S. and the U.K. In light of these results, the study found relational mobility to be associated with greater shame proneness towards a close relationship but not a stranger. Finally, as predicted, the relationship between shame proneness and culture was partially mediated by relational mobility (Sznycer et al., 2012). This study sheds light on the significant cross-cultural differences of shame proneness, which were explained in terms of various elements relating to interpersonal relationships. The study, however, did not offer any explanations regarding the intrapsychic experience of the person experiencing shame, such as anger. Moreover, the study was limited to the Eastern culture of Japan, and thus, may not generalize to other non-Western cultures.

Shame in the Middle East. Cross-cultural differences of shame between Middle Eastern and Western cultures have also been found (Bierbrauer, 1992; Grey et al., 2018). However, research among this population, and in this subject matter, has been extremely scarce. Although, as discussed earlier (see Middle Eastern Culture section), shame and honor are paramount concepts in Middle Eastern culture, empirical research in this area is extremely limited. The few studies that do exist are replete with methodological limitations. For example, a qualitative study in Turkey explored shame experiences in nine adult Turkish women with depression (Sarı & Gençöz, 2016). The study utilized semi-structured interviews with each of the participants. Results of the study showed four significant themes that emerged among the women: "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." While this study provides a clear and descriptive account of shame

experiences among Middle Eastern women, the small number of participants significantly limits the generalizability of the results.

A recent empirical study assessed cross-cultural shame and guilt proneness differences between 120 female university participants from the Republic of Ireland and 115 participants from the United Arab Emirates (UAE) (Grey et al., 2018). The participants' cultural orientation was measured using the Auckland Individualism and Collectivism Scale (AICS; Shulruf et al., 2007), while shame (negative self-evaluation and withdrawal) and guilt (negative behavior evaluation and repair action) were measured using the Guilt and Shame Proneness Scale (GASP; Cohen et al., 2011). The study hypothesized that the Irish sample would report more individualistic tendencies while the UAE sample would report significantly more collectivistic tendencies, and that collectivism would be associated with more shame proneness while individualism would be linked to guilt proneness. At first glance, the results of the study did not support these hypotheses. The AICS failed to distinguish between the two samples, and thus all hypotheses that are based on collectivism and individualism failed to be established. Nevertheless, careful examination of the data would reveal that the UAE subjects did indeed report significantly higher levels of shame-negative self-evaluation and higher levels of shame-withdrawal. Additionally, contrary to the authors' expectations, the study found significantly higher levels of guilt-negative behavior and guilt-repair in the UAE sample compared with the Irish sample (Grey et al., 2018). The study concluded that both shame and guilt are highly prevalent among women from the UAE. This study was limited in several ways. First, the study was conducted among college-age female participants, between 18 and 29 years old, from Ireland and the UAE, which limited the

generalizability of the results. Additionally, the use of the AICS was discovered to be a

serious limitation in this study as it was not sensitive enough to the differences between

the cultural orientation of the subjects.

The effects of the violation of internalized values and norms in relation to guilt

and shame were investigated in a cross-cultural analysis of shame and guilt among

Middle Eastern and Western participants (Bierbrauer, 1992). The study explored

different sources of legitimacy, including law, religion, and traditions, and their effects on

reactions of shame and guilt cross-culturally. The sample consisted of three culture

groups: German, Kurds, and Lebanese. All participants identified as male. Twenty-eight

Kurdish participants from Turkey, 41 Arab participants from Lebanon, and 37 German

participants were asked to complete the Individualism-Collectivism Scale (INDCOL;

Hui, 1988). Shame was measured through three questions: "Someone did not follow the

state laws (religious rules/customs and traditions of his native country, respectively).

Should he be less respected by his peers?" To assess for guilt, participants were asked:

"Imagine someone committed an act contrary to the state laws (religious rules/customs

and traditions of his native country, respectively). His peers are not aware of this. Should

he feel guilty anyway?" Legitimacy was measured by asking the participants three

questions: "Should people follow state laws (religious norms/tradition, respectively)?"

The participants' degree of religiosity was assessed categorically by asking the

participants, "Would you describe yourself as a religious person?" This study based its

hypotheses on the assumption that legal behavior and social conduct are controlled by

external sanctions and by the internalization of norms and values (Bierbrauer, 1992). The

results showed that Kurdish and Lebanese participants scored significantly higher on the

collectivism scale compared with the German participants; thus, the Kurds and Lebanese were combined into a collectivistic group while the Germans constituted the individualistic group. Results also showed that the collectivistic group showed a higher degree of shame and guilt compared with the individualistic group. Collectivism scores, regardless of the group, were correlated with shame and guilt. The Kurds and the Lebanese reported more willingness to keep the norms of religion and tradition but did not differ from the German group with regard to state laws. Finally, results showed that religiosity was significantly correlated with shame and guilt (Bierbrauer, 1992). The results of this study continued to show the expected differences in shame proneness in Middle Eastern compared with Western cultures. However, besides the INDCOL, the lack of validated and reliable measures poses a significant limitation of this study. Additionally, the study was only conducted among male participants. This is a limitation given that women have been found to report significantly more shame compared to men (Lewis, 1976; Wright et al., 1989). Similar to the higher incidence of shame proneness in women, depression and depressive tendencies are also more common in women compared with men.

Depression

Depression and shame. As discussed earlier, a robust link has been established between shame and depression (Caldwell-Harris & Ayçiegi, 2006; Harder et al., 1992; Rüsch et al., 2006). Kim and colleagues (2011) conducted a metanalytic review of the relationship between shame and depression. The review outlined elements of shame that are closely associated with depression. First, shame plays the role of a signal that alerts the individual to the possibility of social rejection and low social status (Kim et al.,

2011). If this signal fails, the individual is at risk of many critical social determinants that are closely associated with depressed affect (Gruenewald et al., 2007). Another element of shame that strongly links it to depressed affect is the focus on bad self. Such perception of the self is likely to elicit negative ruminations that have been shown to predict depression (Nolen-Hoeksema, 2000). In fact, a recent study showed an association between guilt-free shame and ruminations (Joireman, 2004). Other links between shame and depression include the subjective feelings of being small, worthless, and helpless (Kim et al., 2011). The meta-analysis included 108 studies that were published between 1987 and 2010. The analysis included studies that measured shame and/or guilt and depressive symptoms using self-report measures that produced quantitative values of all constructs (Kim et al., 2011). Overall, the analysis included data from 22,411 participants with a mean age of 26.8 years old. Of the 22,411 participants, 66.6 percent were female, and 73.8 percent were White. The most frequently used measure of depressive symptoms was the BDI, and the most frequently used measure of shame and guilt was the TOSCA. Results of the study supported the hypothesis that shame is more strongly associated with depressive symptoms compared to guilt. The study concluded that, based on over 20 years of data generated from over 2,000 participants, "shame warrants much greater prominence in understandings of the underpinnings of depressive symptoms" (Kim et al., 2011, p. 87).

Anaclitic Depressive Style. Depression has been conceptualized multidimensionally due to the vast differences in developmental vulnerability and phenomenology (Reis & Grenyer, 2002). Regardless of whether an individual meets the diagnostic criteria for depression, people present with different depressive personality

styles. Two common depressive styles that reflect different aspects of personality structures are anaclitic and introjective styles (Blatt et al., 1982, 1995). Excessive interpersonal concerns characterize a dependent, or anaclitic, style of depression. Specifically, this personality style involves feelings of loneliness, helplessness, and fear of abandonment. Dependent individuals tend to be hypersensitive to perceived rejection from others (Blatt, 1995; Blatt & Homann, 1992a). Introjectives, on the other hand, are characterized by negative self-evaluation. They have chronic low self-esteem, which they attempt to manage through unrealistic strivings, further perpetuating failure experiences.

There is some theoretical support for a link between shame and anaclitic or dependent personality styles. For instance, there is a link between a field-dependent model of ego functioning, which is associated with feelings of humiliation, embarrassment, ridicule and exposure of private details, and shame (Lewis, 1971). Conversely, a field-independent model, which is associated with guilt, was described in relation to feelings of fault, responsibility, being punished, and abused. This suggested link is based on the shared elements of dependency and fear of abandonment or rejection in both anaclitic and shame prone individuals. However, this belief is not unanimously shared among researchers studying shame and depression. Golan (2001) argued that the self-critical aspects of the introjectives play an even larger role than dependency does in increasing feelings of shame. He argued that viewing oneself as deficient, lacking, and not "good enough," all aspects of an introjective personality structure, are more consistent with shame proneness (Golan, 2001). Little empirical research has been conducted in this area to clarify this discrepancy.

One study examined the role of attachment styles and dependency in a female sample, using the DEQ and a measure of adult attachment styles. Results found anxious attachment to be more correlated with dependency and self-criticism than secure attachment (Zuroff & Fitzpatrick 1995). Moreover, the results indicated a stronger association between anxious attachment and dependency than with self-criticism. These results support the idea that dependency, fear of abandonment, and preoccupation with interpersonal relationships, all aspects of an anxious attachment style and characteristic of shame, are related to depression. These results were replicated in a study of 245 college students (Reis & Grenyer, 2002). In this study, the researchers examined possible differential attachment patterns for the two depression subtypes, introjective, and anaclitic. The participants were asked to complete the Relationships Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994), the Multidimensional Perfectionism Scale (MPS; Hewitt et al., 1991), the DEQ, and the BDI. Similar to the study above, results showed that both preoccupied and fearful-avoidant attachment styles predicted depressive experiences (Reis & Grenyer, 2002). Anaclitic depression was predicted by preoccupied attachment, while introjective depression was predicted by fearful avoidant attachment. The DEQ and the BDI were found to have a significant but weak relationship, suggesting that the measures are related yet distinct. While the two studies discussed above suggest a link between anaclitic depression and shame, more robust empirical research is needed in this area. Clarifying the relationship between shame and Blatt's models of depression would be especially useful when investigating shame in cultures that are less prone to respond to symptom-based inventories.

Depression in the Middle East. Depression has been referred to as the "silent epidemic" among Middle Eastern women. Epidemiological data suggest that depression is one of the most prevalent mental illnesses in the Middle East, with rates ranging between 13 to 18 percent of the general population (Eloul et al., 2009). Data also suggests, similar to global findings, that women from the Middle East are four times more likely to be diagnosed with a depressive disorder compared to men (Eloul et al., 2009; Schwartz, 1991; Trivedi et al., 2007). Some theories have been suggested as possible contributors to the high prevalence of depression among Middle Eastern women. One theory posits that the transition from traditional to modern lifestyle in the Middle East has created a struggle between a woman's traditional role as a wife and mother and her role in higher education and the workforce (Al-Lamky, 2007). Attempting to reconcile these two conflicting worlds may increase stress levels, which may cause heightened anxiety and depression. Women are made to feel as though they are not fulfilling their duties as daughters, wives, and mothers, or to think that they are neglecting their self-actualization and autonomy (Schwartz, 1991). Many suggest that the rapid modernization in the Middle East has not been equally paralleled by a change in the cultural values concerning the structure of the roles of the family (Al-Lamky, 2007; Daradkeh et al., 2002).

These factors may be further amplified in women who immigrate from conservative Middle Eastern countries to significantly modernized Western countries. Research has indicated that issues such as one's religion (Awad, 2010), socioeconomic status (Polek et al., 2008), length of stay in the host country (Cortes et al., 1994), age at immigration (Stevens, 1999), and educational level (Bjelland et al., 2008) play a

significant role in the level of acculturation. Accultarive stress has been linked to the development of mental health symptoms, including depression, anxiety, and suicidal ideation (Hovey, 2000; Organista et al., 2003; Torres & Rollock, 2004).

Research data regarding the prevalence of depression in the Middle East is inconsistent. For example, Obermeyer and colleagues (2015) highlighted scattered data on the prevalence of mental health across the region. For instance, estimated prevalence rates of 16% were reported in Saudi Arabia and Lebanon, while an estimated prevalence of 66% was reported in Jordan. Additionally, inconsistencies within countries have also been reported. In a recent study of older Egyptian and Jordanian individuals, 60 years and older, 84.2% of the participants reported a score of 16 and above on the Center of Epidemiologic Studies Depression Scale, indicating high depressive symptoms (Abu-Bader et al., 2017). In another study conducted in Egypt among women ages 18 and up, 33% of the sample reported depressive symptoms, with 18% being severely depressed. Conversely, an epidemiology study in Egypt suggested that the prevalence of depression is approximately 11.4% among Egyptians living in urban cities, and 19.7% for those living in rural areas (Okasha, 1999). Some possible explanations regarding the discrepancy in prevalence rates of depression were offered. First, some suggest that the current check-lists and symptom-focused scales of depression may not be suitable for cross-cultural populations (Al-Adawi et al., 2007). Another possible reason for the discrepancy in prevalence rates may relate to the stigma associated with mental illness in the Middle East (Al-Sinawi & Al-Adawi, 2006). Due to this, women were reported to 'mask' their depression in order not to disgrace their family (Al-Krenawi, 2005; Nasir & Al-Qutob, 2005). Given this information, it is imperative to capture all the different ways

in which depression may manifest among Middle Easterners by assessing both depressive symptomology as well as depressive personality styles.

Studies investigating depression in an Egyptian sample found that depressed mood is often manifested in somatic symptoms and agitation (Gawad & Arafa, 1980; Okasha et al., 1977). Other symptoms included hypochondriasis, decreased libido, anorexia, and insomnia. This study revealed that Egyptian subjects tended to translate their feelings into physical complaints, as these symptoms are more socially acceptable than psychological complaints, which are often ignored or not taken seriously. Okasha (1999) explained the increased use of somatization as a function of the seriousness with which people view psychological stress compared to physical illness in the Middle East. Given the suggested high, yet inconsistent prevalence of depression in Middle Eastern women, it is essential to conduct studies that use culturally appropriate measures in order to fill this gap in the literature. This can be achieved through assessing depression as a multifaceted disorder, focusing not only on specific symptoms but also on personality structures. In addition to identifying culturally sensitive ways of measuring depression, research exploring various factors that could lead to depression in this population is needed. One factor that has been identified to contribute to depressed feelings is anger suppression.

Anger Suppression

Freud (1927) believed that fear and aggression are the main instincts that drive human behavior. Self-destructive behavior is directed towards the outer world in the form of aggression. However, aggression that cannot be vented against the external world is redirected back towards the self, resulting in pathological symptoms including

depression and psychosomatic symptoms (Alexander & French, 1948; Freud, 1936).

Spielberger (1988) highlighted the ways anger is expressed. While verbal and physical

behavior towards others are common ways of anger expression, suppressing angry

feelings is another form of anger expression (Spielberger et al., 1995). One study

measured anger-out (aggressive behavior) versus anger-in (anger suppression) in a

sample of healthy college students (Funkenstein et al., 1954). Results showed that

participants who suppressed their anger had increased pulse rate, three times greater than

that of participants who expressed their anger through aggression. Suppressed anger has

also been associated with elevated blood pressure and hypertension (e.g., Hosseini et al.,

2011) and chronic pain (Burns et al., 2008; Kerns et al., 1994). Anger suppression has

been found to be a significant mediating factor with several constructs, including

depression and interdependent self construal (Cheung & Park, 2010).

  Shame and Anger Suppression. In discussing the negative emotions associated

with shame, Tangney emphasized the pressure the shame prone individual places on

inhibiting the expression of socially and morally unacceptable impulses, including

aggression (Tangney et al., 1992). The link between shame and anger was also noted by

Lewis (1971). Based on her clinical case studies, she posited that intense feelings of

shame lead to humiliated fury, which is first directed at the self. However, since shame

involves a real or imagined disapproving other, the ashamed individual directs the anger

towards the rejecting other. This defense is often short-lived as the ashamed individual

recognizes that their anger is unjust or inappropriate, leading to even more shame (Lewis,

1987).

Tangney and colleagues (1992) conducted two studies to measure the differential relationship between guilt, shame, and anger. Data for the studies were collected from 243 and 252 undergraduate students attending a large East Coast university. The majority of the participants were female (71 percent) and White (77 and 81 percent, respectively). Measures for the studies included the SCAAI, TOSCA, SCL-90, Trait Anger Scale (TAS; Spielberger et al., 1988), and the Buss-Durkee Hostility Inventory (Buss & Durkee, 1957). Results of the two studies showed that shame proneness was consistently and positively correlated with anger arousal, suspiciousness, resentment, irritability, a tendency to blame others for negative events, and indirect expression of hostility (Tangney et al., 1992). The authors of the study interpreted the results such that an initial sense of shame leads to fury and hostility. This assumption was made based on previous clinical observations (e.g., Lewis, 1971; Scheff, 1987). However, since the study was correlational, this directionality could not be proven, which constitutes a limitation of these studies. Additionally, the homogeneity of the sample was another shortfall of the study.

The link between shame and anger has been found across the lifespan (Tangney et al., 1996, 1991). However, the way by which anger is expressed seems to vary. For example, while fifth-grade boys seemed to react to shame by showing direct aggressive behavior (Tangney et al., 1991), undergraduate students exhibited more resentment and indirect aggression (Tangney et al., 1992). In order to measure these differences, Tangney and colleagues (1996) conducted a cross-sectional study to assess anger management and expression across the life span in relation to shame and guilt. Participants consisted of 302 children, 427 adolescents, 176 college students, and 194

adult travelers passing through a large urban airport. Subjects were asked to complete

age-appropriate versions of the TOSCA and the Anger Response Inventories (ARI;

Tangney et al., 1996). The results of the study highlighted the different roles that shame

and guilt play on anger expression. Specifically, guilt was seen as the more "moral"

emotion, predicting constructive responses to anger, while shame was associated with

maladaptive and unconstructive responses to anger (Tangney et al., 1996). This finding

was consistent across the entire sample, regardless of age. Additionally, the degree of

shame proneness was also associated with the degree of anger. In other words, the more

shame prone participants were, the more anger they reported regardless of their age.

Moreover, the study found that shame proneness was associated with anger suppression,

self-directed hostility, and a tendency to withdraw from situations that give rise to

feelings of anger (Tangney et al., 1996). Although the study hypothesized age to play a

significant role in the expression of anger relating to shame and guilt, results did not

support this hypothesis. Instead, the study found a consistency in the relationship

between shame and maladaptive responses to anger, including anger suppression. One

limitation of this study was the homogeneity of the sample with regard to race and ethnic

identity.

      A connection between shame proneness and anger suppression was also found in

another study of 174 female and 91 male college students (Lutwak et al., 2001). The

study investigated gender differences in shame and guilt proneness, anger suppression,

and expectations for success. Measures utilized in this study included the TOSCA, the

Generalized Expectancy for Success Scale (GESS; Fibel & Hale, 1978), and the Anger

Expression Scale (AX; Spielberger, 1988). Results supported the study's expectations of

a gender difference in shame and guilt proneness. Specifically, female participants reported significantly more shame proneness, while male participants reported significantly more guilt proneness (Lutwak et al., 2001). Additionally, female participants were significantly more likely to report anger suppression compared with male participants. Overall, the study supported previous research highlighting gender differences in shame and guilt proneness, as well as emphasized the association between shame and anger suppression.

  Anger Suppression and Depression. Anger has been characterized as an emotion that relates to the independent and autonomous self (Markus & Kitayama, 1991). Anger suppression refers to the frequency with which one experiences anger but does not express it (Spielberger, 2010). The ability to express anger signals a capacity to be in touch with one's rights and needs, to be assertive, and indicates an active effort to correct a problem or fix an injustice (Bernardez, 1987; Cox et al., 2000; Miller & Surrey, 1997). Anger suppression, on the other hand, has been associated with conflict avoidance, irritability, ruminations, higher levels of depression (Bridewell & Chang, 1997; Martin & Dahlen, 2007) and lower levels of life satisfaction (Gross & John, 2003). Moreover, anger suppression has been found to be particularly higher among depressed women (Dropplemann & Wilt, 1993; Jones et al., 1992; Sperberg & Stabb, 1998). Feminist writers have discussed the negative consequences of societal norms that inhibit women's expression of anger (Crawford et al., 1992). As discussed earlier, robust research findings suggest a significant gender difference in depression prevalence, with women being significantly more likely to experience depression than men (e.g., Anderson & Holder, 1989; Frank et al., 1988; Frankel, 1992). Some theories have posited that the

nature of relationships that women are engaged in may partially explain this higher

proneness for depression (Chodorow, 1978; Gilligan et al., 1990). Women were found to

value connection with others over attunement and expression of internal feelings,

especially ones that may risk relationship stability (Cox et al., 2000). This need to

preserve relationships at the cost of suppressing feelings is dangerous. Adjustment

problems, such as eating disorders, negative self and body image, hopelessness, and

suicide, have been found to relate to the internalization of distress and the overcontrol of

impulses (Gjerde & Block, 1991).

Anger suppression and depressive symptoms were examined among 161

elementary, middle, and high school students (Cox et al., 2000). The study sample was

racially diverse, with 41.6 percent African Americans, 27.9 percent Latino, 26.7 percent

White, and 3.7 percent Asian; 62.7 percent of the sample were girls. Participants were

asked to complete the Pediatric Anger Expression Scale III (PAES-III; Phelps & Rohrs,

1989) and the Children's Depression Inventory (CDI; Kovacs, 1992). Results supported

the hypothesis that girls engage in more anger suppression than boys. Girls endorsed

items such as, "I hold my anger in," "I get mad inside but I don't show it," and "I'm

afraid to show my anger." The study, however, did not support the anger suppression and

depression link (Cox et al., 2000). One explanation for this unexpected non-significant

relationship may be related to the young age of the participants. It is possible that the

link between anger suppression and depression is more likely to be observed when

suppression of anger is persistent over a long period of time. In fact, in an adult sample,

Gross and John (2003) found that individuals who are habitual suppressors were

significantly more depressed compared with individuals who use reappraisal as an

emotion regulation strategy. Similarly, in an adult study of 234 female participants, Sperberg and Stabb (1998) examined depression relating to anger suppression or inappropriate anger expression and relationship mutuality. The results showed several interesting findings. Of relevance to the topic of this dissertation, results showed that higher levels of anger suppression and inappropriate anger expression were associated with higher severity of depression (Sperberg & Stabb, 1998). The results of the studies mentioned above support the hypothesis of a link between anger suppression and depression; however, the lack of studies examining anger suppression across different cultural groups constitutes a serious gap in the literature. Another area where data appears to be seriously lacking, especially in Middle Eastern populations, is research on shame and religiosity.

Religiosity

Religiosity in the Middle East. Religion plays a central role in the lives of many Middle Easterners and is extremely intertwined with Arab culture (Amer & Hovey, 2007). While Islam and Christianity are the most widely practiced religions in the Middle East, Judaism and Hinduism are also represented in some Middle Eastern countries (Haboush & Alya, 2013). Regardless of the religion, Islam tends to be an encompassing way of life that has influences on norms for family roles and lifestyle, and not just religious practices (Ali et al., 2004). For example, both Muslims and Christians in the Middle East emphasize the importance of family honor and filial piety (Ajrouch, 2004). The U.S. Census estimates that approximately one million Muslims are residing in the United States; however, approximately 29 percent, the largest percentage, of Arab

Americans are Lebanese Christians (Arab American Institute, 2011; Al-Romi, 2000; Nassar-McMillian & Hakim-Larson, 2003).

Religiosity and Shame. Researchers studying the Judeo-Christian tradition believe that highly religious individuals are more susceptible to feelings of shame and guilt than non-believers (Reisner & Lawson, 1992). Certain aspects of religiosity have been found to lead to emotional distress through messages of shame and guilt. Specifically, psychodynamic theorists posit that the strong emphasis on sin, which closely resembles feelings of shame in that the global self is under scrutiny, increases vulnerability to psychological maladjustment (Bierbrauer, 1992; Hood, 1992; Lester, 2012). For example, in a study of 149 undergraduate students, measures of religiosity were found to be positively correlated with measures of depression, mania, and past suicidal ideation (Lester, 2012). Another study of 400 patients with unipolar major depression and 167 nondepressed subjects found religion to be related to a diagnosis of depression (Hayward et al., 2012). The degree of religiosity is also thought to increase feelings of shame and guilt. For instance, orthodoxy, which is highly dogmatic, has been found to correlate strongly with psychological symptoms, such as depression and anger (Luyten et al., 1998). Nevertheless, research in this area has been inconsistent (Chaaya et al., 2007). In fact, many researchers suggest that despite the link between shame and religiosity, religion can attenuate or even prevent the adverse effects of shame and guilt (Luyten et al., 1998; Pargament, 1996; Stack, 1992). More research in this area is needed in order to resolve the current discrepancies and shed light on the particular aspects of religion that either attenuate or strengthen the proposed link. Additionally, more robust

research should focus on other widely practiced religions, such as Islam, when exploring this link.

     Religiosity and Anger Suppression. Based on Dunn's (1965) review of studies on personality measurements, especially the MMPI, individuals who are "religious-prone" appear to have more perfectionistic tendencies and to be more withdrawn and insecure. Swindell and L'Abate (1970) interpreted such results to indicate that highly religious individuals may be "closing out" threatening stimuli by avoiding or denying them, thus scoring higher on the Repression-Sensitization scale of the MMPI. This repression of unwelcomed experiences, including anger, is likely to lead to depressive symptoms that are outside one's consciousness.

     A number of studies, across different religions, have examined the effects of sexual-religious conflicts in highly religious individuals (Coyle, 2011; Schachter, 2004). For example, a recent qualitative study investigated the personal experiences of heterosexual Orthodox Jewish men with regard to sexual desires and religious laws (Frances, 2008). According to religious laws, Orthodox Jews are prohibited from masturbating and from engaging in any form of premarital physical intimacy. The internalization of such laws may lead to conflictual feelings that can impact intimate relationships, religiosity, and overall emotional well-being (Frances, 2008).

     Research on religiosity and anger is scarce. The few available studies do not paint a clear picture regarding the relationship between these two constructs. For example, some studies have proposed that religion is a protective factor against mental illness. Some studies found a positive and significant relationship between spirituality and coping responses in adolescents and early adulthood (e.g., Krause et al., 2001; Young

et al., 2000). Contrary to these findings, one study of 192 adolescents found a link

between extrinsic religious orientations and anger suppression (Beeksma, 2009).

Similarly, in a study of college students, spirituality was significantly and positively

related to anger (Carlozzi et al., 2010). Similar findings were reported in a study of 53

eighth and ninth-grade students from a southwestern state (Carlozzi et al., 2010). More

robust research needs to be conducted in this area to solve discrepant findings and to

generalize results to broader populations and religious orientations. In addition to

religiosity, interdependent self construal is another important factor of relevance in

discussions about shame.

Interdependent Self Construal

Markus and Kitayama (1991) define an interdependent self as one that is

inherently connected and meaningful through the relationships with other individuals.

Additionally, they believe that one's thoughts and actions are shaped and determined to a

large extent by what they perceive the thoughts, feelings, and actions of others in the

relationship may be. Thus, this understanding of the self as an interdependent agent does

not view the self as separate but as connected and less differentiated from others.

Important others play an integral role in the formulation of the self and contribute

significantly to one's self-esteem and opinions. Unlike individuals with an independent

self construal who value autonomy, independence, and self-expression, individuals with

an interdependent self construal view such concepts as secondary to the primary task of

interdependence (Markus & Kitayama, 1991). To such individuals, social interactions

create a sense of self that is connected with others (Markus & Kitayama, 2010). These

interactions are guided by tasks that encourage fitting in, adjusting to others, and using others as referents for actions.

Different cultures have different construals of self. An established link has been found between collectivist cultures and interdependent self construal. For example, in Chinese culture, there is a tendency for people to act in line with the anticipated expectations of others, regardless of personal desires and wishes (Yang, 1981). There is a clear Confucian emphasis on interrelatedness and kindness. Other collective cultures that show high rates of interdependence include Hispanics (Triandis et al., 1984), Filipinos (Church, 1987), Hindus (Marriott, 1976), and Africans (Beattie, 1980). In a study of 125 male Arab immigrants from Egypt, Iraq, Kuwait, Lebanon, Morocco, Palestine, and UAE, interdependent self construal was found to be highly correlated with Arab ethnic identity (Barry et al., 2000). Besides this study, which carries some limitations, including the all-male sample, research on interdependent self construal in Arabs is almost non-existent.

Interdependent Self Construal and Shame. Although not robust, there is some research that suggests a relationship between interdependent self construal and shame (Dean & Fles, 2016; Lutwak et al., 1998). Dean and Fles (2016) investigated the nature of the self that is involved in the experience of shame and guilt. They posited that different conceptualizations of the self likely influence reactions to transgressions. Namely, individuals with an interdependent self construal have worries about maintaining social bonds, which may trigger feelings of shame in the face of transgressions (Dean & Fles, 2016). In a study of 147 undergraduate students, results showed that independent self construal fostered guilt related cognitions while

interdependent self construal fostered shame related cognitions (Dean & Fles, 2016). The

relationship between interdependent self construal and shame increased the more strongly

a person defined the self as interconnected with others. In a cross-cultural study between

Asian and European American community college students, Asian students reported

significantly more shame than their counterparts (Miller, 2002). This relationship

between culture and shame was found to be mediated by a strong interdependent self

construal.

Additionally, due to the interconnectedness of individuals with interdependent

self construal and the lack of boundaries between self and close others, transgressions of

family members and close friends appear to cause feelings of shame. One study

investigated transferred shame in individuals high on interdependent self construal (Wang

et al., 2008). The subject pool consisted of 163 Chinese and 196 American participants.

Subjects were asked to rate their reactions to shameful scenarios involving five different

individuals, ranging in closeness from self to stranger. Results showed that the Chinese

participants, who are high on interdependent self construal, experienced higher levels of

shame than the American participants. Additionally, as would be expected, the closeness

of the relationship, for example, mother versus classmate, resulted in a significant

difference in the degree of shame experienced (Wang et al., 2008).

Interdependent Self Construal and Depression. People with an interdependent

self construal interact very differently with their environment compared to those with an

independent self construal (Mak et al., 2011). Such differences in approaching the

environment likely leads to differing psychological symptoms. For example, sociotropy

is a cognitive style that is characterized by an exaggerated sense of relation to others

(Beck et al., 1983; Luthar & Blatt, 1993). An individual with a sociotropic cognitive style strives to please others and experiences significant fear of abandonment and rejection (Blatt & Zuroff, 1992b). Thus, one would assume that individuals with a high interdependent self construal, who also value group membership and interconnectedness, to be more likely to develop sociotropy than those with an independent self construal. A sociotropic cognitive style has been linked to depression (Beck et al., 1983; Fresco et al., 2001; Sato et al., 2004). Therefore, indirectly, high interdependent self construal is expected to be associated with increased depressive symptoms.

To test the interactions between self-construal, sociotropy, anxiety, and depression, Mak and colleagues (2011) recruited 212 Asian American and 202 European American participants. Participants completed the Interdependence-Independence Scale (IIS; Kato & Markus, 1992), the General Ethnicity Questionnaire (GEQ; Tsai et al., 2000); the sociotropy scale of the Personal Style Inventory (PSI; Robins et al., 1994), and the Center for Epidemiologic Studies-Depression Scale (CES-D; Radloff, 1977). Results revealed that Asian American participants were significantly more depressed than European Americans (Mak et al., 2011). Results also showed that Asian Americans had stronger interdependent self construal compared with European Americans. Specifically, they reported being more likely to define themselves in relation to others and to value harmony among relationships. Such characteristics seemed to place Asian Americans at a higher risk of developing socially related cognitive vulnerability, including sociotropy. Results also indicated that, regardless of ethnicity, individuals with high interdependent self construal are more likely to develop sociotropy and to be overly concerned with how others perceive them. The study concluded that it is not ethnicity that placed some of the

participants at a higher risk of depression but a higher degree of interdependent self construal (Mak et al., 2011). Nevertheless, more exploration into the role of ethnic identity into shame and depression is warranted.

Middle Eastern Ethnic Identity.

As discussed earlier (see Middle Eastern section), Middle Easterners have many shared norms, values, and belief systems (Haboush & Alya, 2013). Among such values and beliefs are the concepts of honor and shame. The strong emphasis on these constructs shape the cognitions, emotions, and behaviors of Middle Eastern individuals. Moreover, there is an even stronger pressure on women to preserve family honor through obedience and self-sacrifice (Ajrocuh, 2004; Kulwicki, 2002). This expectation of self-silencing and repressing personal desires may explain the higher rates of depression among Middle Eastern women. Since ethnic identity is predicted to positively predict adherence to cultural values (Gaines et al., 2013), one would expect that a stronger Middle Eastern ethnic identity would lead to stronger feelings of shame, and thus depression. One study found that Arab Americans with a strong sense of ethnic identity were also likely to report a stronger interdependent self construal (Barry et al., 2000). However, the study was limited in its use of an all-male, immigrant, sample. More robust research needs to be conducted in this area in order to shed light on risk factors that may strengthen the relationship between shame and depression in Middle Easterners.

CHAPTER III

Statement of the Problem

The collectivistic nature of Middle Eastern culture promotes defining oneself in terms of one's ingroup, preserving family honor, and placing the welfare of the family over that of the individual (Haboush & Alyan, 2013). Children, especially daughters, are expected to make sacrifices and are taught from a young age that their behavior is a reflection on their family (Dwairy & Van Sickle, 1996). Such emphasis on the other is likely to increase feelings of shame, which is often understood as a reaction to the imagery of an explicit or implicit disapproving other, and which often involves a sense of exposure (Tangney, 1992). Despite the strong emphasis on honor and shame among Middle Easterners, empirical research in this area remains scarce.

Shame is a negative emotive experience that has been associated with a plethora of psychopathology (Grey et al., 2018). A strong and robust link has been established between shame and depression in particular (Kim et al., 2011). A growing body of research suggests that shame prone individuals may be at increased risk of developing depression (Tangney et al., 1992). Further, besides clinical depressive symptomology, a connection has been drawn between shame and Blatt's anaclitic depressive style, due to the characterization of depression as "loneliness and emptiness" (Lewis, 1987). Although depression has been found to be one of the leading contributors to mental illness in the Middle East, and despite the robust link between shame and depression, there remains a lack of empirical investigation between these two constructs in a Middle Eastern population. As such, this study aimed to fill this gap in the literature by investigating whether high shame proneness indeed leads to increased depression

severity, on a symptom level, in a sample of female Middle Eastern participants. Additionally, since depression is a multifaceted concept that encompasses more than diagnostic criteria, the study also explored the relationship between dependency, operationalized from the purview of Blatt's anaclitic depression, and shame proneness.

The abovementioned relationship between shame and depression is impacted by a number of factors, one of which is anger suppression. Lewis (1971) posited that the pain resulting from shame becomes so intolerable that it turns into fury, first towards the self and later towards the other. Relatedly, Tangney and colleagues (1996) found that shame prone individuals experience more anger than their less shame prone peers. This study found that shame proneness was associated with suppressed anger, self-directed hostility, and a complete withdrawal from anger-related situations. Moreover, anger suppression has consistently been found to lead to depressed symptomology (Bridewell & Chang, 1997). Specifically, suppressed anger, and other ineffective means of anger expression, including crying and displacement, have been implicated in women's depression (Frankel, 1992; Miller & Surrey, 1997). Given the cultural emphasis on sacrificing one's needs for the family and the expectation that women are to be compliant and obedient, one would expect anger suppression to be exceptionally high among Middle Eastern women. However, there has been no research to date that has investigated the mediating effects of anger suppression on depression in a female Middle Eastern sample. Thus, this study explored the proposed mediating effect of anger suppression on depression in a sample of female Middle Eastern participants, with the expectation that the increased use of anger suppression in highly shame prone participants would partly explain the severity of their reported depression.

Another factor that is essential to investigate concerning shame in a Middle Eastern population is religiosity. Research findings have been mixed regarding the effects of high religiosity on mental illness (Chaaya et al., 2007). While some findings support the idea that religion can be a protective factor against depression (Berry & York, 2011), others have found certain aspects of religiosity to lead to emotional strain through messages of shame and guilt (Reisner & Lawson, 1992). This discrepancy is interesting and certainly worth exploring in a population where religion plays a major role in shaping the thoughts and behaviors of its individuals. Still, studies investigating the effects of religiosity on mental health in the Middle East are scarce (Chaaya et al., 2007). Additionally, there is a paucity in the literature in general regarding religiosity and anger suppression. To fill this gap in the literature, this study investigated the role of religiosity on anger suppression with the expectation that individuals who are highly shame prone and highly religious would report a higher tendency for anger suppression compared with individuals who report lower levels of religiosity.

Finally, culture is also expected to have a significant impact on the relationship between shame and depression in the proposed population. Specifically, two aspects of culture: interdependent self construal and Middle Eastern ethnic identity, are expected to further strengthen the link between shame proneness and depressive symptomology. A society that is high on interdependent self construal assumes that individuals are inherently connected and sees the self as meaningful through the relationships with others (Markus & Kitayama, 2010). This interconnectedness would then lead one to assume that the pain of transgressing would be amplified given that it not only impacts oneself but close others as well. In light of this, this study hypothesized that shame prone

individuals who are high on interdependent self construal would be expected to feel significantly more distress compared to individuals who are low on interdependent self construal. The second cultural aspect that was investigated in this study is Middle Eastern ethnic identity. Since honor and shame are deep-rooted Middle Eastern cultural values, one would expect that stronger identification with one's Middle Eastern ethnic identity would lead to an even stronger relationship between shame and depression. Despite the major influence of culture on the thoughts and behaviors of Middle Eastern women, this area of research remains unexplored. As such, the current study hypothesized that Middle Eastern ethnic identity would further strengthen the relationship between shame and depression.

The present study aimed to shed light on aspects of Middle Eastern culture that increase the risk of depression. The study presumed that a deeper understanding of the effects of shame proneness in Middle Eastern women would help guide clinical diagnoses and treatment of this increasingly growing cultural group in the United States. The research data also provided information to facilitate the administration of culturally informed psychotherapy in this population. Finally, understanding the roles of different intrapsychic and cultural factors, including anger suppression, religiosity, self construal, and ethnic identity, further informed the conceptualization of the social, psychological, and emotional functioning of Middle Eastern patients. While changing an entire culture's emphasis on honor and shame is a daunting task, using informed research data to provide psychoeducation to Middle Eastern parents regarding the harmful effects of shame is a promising start. As such, the present study addressed the question of how anger

suppression, religiosity, interdependent self construal, and ethnic identity influenced the relationship between shame proneness and depression in Middle Eastern women.

Variables

Predictor/Independent Variable

      Shame. Shame occurs when an individual makes global negative attributions about one's self following a breach of moral or social norms (Lewis, 1971; Webb et al., 2007). Shame was operationalized as a high score on the shame proneness scale of the Test of Self-Conscious Affect (TOSCA-3; Tangney et al., 2000). This variable was measured continuously with higher sum-scores indicating higher shame proneness.

Exploratory Independent Variable

      Internalized shame. State internalized shame was assessed through the Internalized Shame Scale (Cook, 2001). Scores were analyzed continuously, with higher sum scores indicating higher levels of internalized shame.

Dependent Variable

      Depression severity. Depression severity was operationalized utilizing the Beck Depression Inventory-II (BDI-II; Beck et al., 1996). Scores were analyzed continuously to assess the participants' severity of depressive symptomology, with higher scores indicating higher depression severity.

Exploratory Dependent Variable

      Dependency. Dependency, or an anaclitic depressive style, is characterized by excessive interpersonal concerns, including loneliness, fear of abandonment, and helplessness. Dependency was operationalized via the Dependency subscale of the

Depression Experience Questionnaire DEQ; Blatt, 1974). Scores were analyzed

continuously, with higher Dependency scores indicating higher levels of dependency.

Proposed Mediator Variable

Anger Suppression. Anger suppression was operationalized as a high score on

the Anger Expression-In subscale of the State-Trait Anger Expression Inventory (STAXI-

2; Spielberger, 2010). This variable was assessed continuously with higher mean scores

indicating higher anger suppression.

Proposed Moderator Variables

Religiosity. Participants' degree of religiosity was operationalized as higher

scores on the Centrality of Religiosity Scale-15 (CRS-15; Huber & Huber, 2012). This

variable was measured continuously using the total score of this measure.

Interdependent Self Construal. Individuals who are high on interdependent self

construal are perceived as connected, fluid, and committed beings who are bound to

others (Markus & Kitayama, 1991). Interdependent self construal was operationalized as

a high score on the Interdependent Self Construal subscale of Singelis's Self Construal

Scale (SCS; Singelis, 1994). This variable was measured continuously with higher mean

sum scores indicating higher levels of interdependent self construal.

Middle Eastern ethnic identity. Ethnic identity was operationalized as "feelings

of ethnic belonging and pride, a secure sense of group membership, and a positive

attitude toward one's ethnic group" (Phinney & Alipuria, 1996, p.142). Ethnic identity

was measured using the Multigroup Ethnic Identity Measure (MEIM; Gaines et al.,

2013). The variable was measured continuously using the mean score of the MEIM, with

higher scores indicating higher levels of Middle Eastern ethnic identity.

Possible Covariates

Age. This variable was assessed continuously using the demographic questionnaire.

 Length of time in the United States. This variable was assessed continuously using the demographic questionnaire.

Socioeconomic Status. This variable was assessed continuously using the demographic questionnaire.

Primary Hypotheses

In a sample of Middle Eastern women participants, it was hypothesized that:

Hypothesis 1. There would be a significant positive main effect of shame on depression severity.

Hypothesis 2a. There would be a significant positive main effect of shame on anger suppression.

Hypothesis 2b. Anger suppression would significantly mediate the relationship between shame on depression severity, such that there would be a significant positive indirect effect of shame on depression severity through anger suppression.

Hypothesis 3a. Religiosity would moderate the relationship between shame and anger suppression, such that the relationship between shame and anger suppression would be significantly stronger and positive as religiosity increased.

Hypothesis 3b. Religiosity would moderate i) the mediated relationship that anger suppression has between the relationship of shame and depression severity, such that the indirect effect of shame on depression severity through anger suppression would be significantly stronger and positive as religiosity increased and ii) the relationship

between shame and depression severity, such that the direct effect of shame on depression severity would be significantly stronger and positive as religiosity increased.

Hypothesis 4a. Interdependent self construal would moderate the relationship between shame and depression severity, such that the relationship between shame and depression would be significantly stronger and positive as interdependent self construal increased.

Hypothesis 4b. Interdependent self construal would moderate the mediated relationship that anger suppression has between the relationship of shame and depression severity, such that the indirect effect of shame on depression severity through anger suppression would be significantly stronger and positive as interdependent self construal increased.

Hypothesis 5a. Middle Eastern ethnic identity would moderate the relationship between shame and depression severity, such that the relationship between shame and depression severity would be significantly stronger and positive as Middle Eastern ethnic identity increased.

Hypothesis 5b. Middle Eastern ethnic identity would moderate the mediated relationship that anger suppression has between the relationship of shame and depression severity, such that the indirect effect of shame on depression severity through anger suppression would be significantly stronger and positive as Middle Eastern ethnic identity increased.

Exploratory Questions

1. Does shame proneness predict higher dependency?

2. Does anger suppression explain the relationship between shame proneness and

    dependency?

3. Does internalized shame predict higher dependency?

CHAPTER IV

Method

Participants

Data for this study were collected from female Middle Eastern participants. A

power analysis, using G*Power (Faul et al., 2007), with five predictor variables, an alpha

level of .05, a small size effect size of .15, and a power of .95 suggested a total sample

size of 138 participants. Data were collected from 213 Middle Eastern female

participants in order to account for missing data. Formal and accepted references define

the Middle East as countries from South-West Asia and North Africa, extending from

Libya to Afghanistan. Other countries that share in the Middle Eastern culture, but do

not geographically fall in the Middle East are Turkey, Morocco, Algeria, and Tunisia

(Mohit, 2001; see Appendix 1 for a complete list of Middle Eastern countries). Multiple

sources were utilized for recruitment. Female Middle Eastern undergraduate students

were recruited through the psychology experience program (PEC) at Long Island

University - Brooklyn campus ($n = 8$). Participants were also recruited through various

Middle Eastern/Arab social clubs across the United States ($n = 205$). A "snowball"

recruitment strategy was implemented to aid in the recruitment of the sample. Data were

collected electronically, via an active link. Institutional Review Board approved

recruitment material was posted on Long Island University's college campus and across

various Middle Eastern social clubs in the Greater New York area. Additionally,

utilizing snowball recruitment, active links were emailed to individuals who voiced

interest in participating in the study and who met inclusion criteria. In order to meet

inclusion criteria, participants had to be female, identify as Middle Eastern/Arab, and be above the age of 18. Exclusion criteria was failure to meet the above inclusion criteria.

Measures

 Demographic **Questionnaire.** Participants were asked to complete a brief demographic questionnaire. Questions included the participants' age, gender identity, sexual identity, race, ethnic identity, marital status, country of birth, the number of years they have lived in the United States, socioeconomic status, and educational level.

 Test of Self-Conscious Affect-3 (TOSCA-3; Tangney et al., 2000). The TOSCA-3 is the most widely used shame and guilt assessment. The measure consists of 16-item scenario-based self-report items. Items are intended to determine shame and guilt proneness through describing a scenario and then several responses, including prototypical shame responses and guilt responses. Participants are asked to rate the likelihood that they would respond that way to each item. An example scenario is "You make plans to meet a friend for lunch. At five o'clock, you realize you have stood your friend up." Participants are then asked to imagine themselves in that scenario and rate the likelihood they would respond in a specific way. Items are presented on a five-point Likert-type scale, ranging from *Not Likely to Very Likely*. Example responses include "You would think 'I'm inconsiderate,'" "You would think you should make it up to your friend as soon as possible," and "You would think 'my boss distracted me just before lunch.'" The measure yields two sum-scores, one for shame proneness and one for guilt proneness. The TOSCA-3 has been reported to yield good reliability, with alphas ranging from .77 to .88 for shame proneness and .70 to .83 for guilt proneness when used in multicultural samples, including Middle Easterners (Dearing & Tangney, 2011;

Ghorbani et al., 2013). The measure has also shown good convergent validity with other measures of shame and guilt in a sample of female and male adolescents (Watson et al., 2015). The TOSCA-3 has been translated into many languages, including Greek and Chinese (Gao, 2013; Gouva et al., 2012)

Internalized Shame Scale (ISS; Cook, 2001). The ISS is a self-report measure of internalized shame. The 30-item measure consists of two subscales, Shame and Self-Esteem. The 24-items measuring internalized shame are rated on a five-point Likert-type scale, ranging from *Never* to *Almost Always*. Example items include "I feel intensely inadequate and full of self-doubt," and "I feel like I am never quite good enough." Total scores range from 0 to 96. The measure has shown good construct validity and reliability in clinical and non-clinical populations (Luoma et al., 2017). The Shame scale of the ISS has shown excellent internal consistency with Cronbach alphas of .96 in community adults with varying levels of alcohol dependency (Luoma et al., 2017) and .88 in a sample of college students (Rosario & White, 2006). The Shame scale has also shown significant test-retest correlations of .81 after 14-weeks of the initial administration (Rosario & White, 2006).

Beck Depression Inventory-II (BDI-II; Beck et al., 1996). The BDI-II is one of the most widely used self-report instruments for measuring depression severity in both clinical and non-clinical populations, including college students (Archer et al., 1991; Steer & Clark, 1997). This measure consists of 21-items scored on a 0-3 Likert-type scale, with higher scores indicating increased severity of depressive symptoms. The BDI-II has shown good convergent validity with other measures of depression, including the Hamilton Depression Rating Scale, $r = .71$ (HDRS; Hamilton, 1960) and the

Sociotropy and Solitude traits from the Beck Anxiety Inventory, $r = .56$ in a sample of

470 outpatient participants (BAI; Steer et al., 1995). Discriminant validity was also

indicated due to the lack of a significant relationship with the Sociotropy and Autonomy

scales (SAS; Clark et al., 1995). The BDI-II has shown excellent internal consistency,

with Cronbach's alpha ranging from .89 to .91 in psychiatric outpatient participants with

various psychiatric disorders (Beck et al., 1996; Steer & Clark, 1997). Finally, an Arabic

version of the BDI-II (Ghareeb, 2000) has also shown excellent internal consistency

when used with college students from 18 Arab countries around the world, with alpha

values ranging from .82 to .93 (Alansari, 2006).

Depressive Experiences Questionnaire (DEQ; Blatt et al., 1976). The DEQ is a

widely used measure for assessing depressive styles in terms of two personality

structures, anaclitic (dependent) and introjective. The measure consists of 66 self-report

items with answers presented on a seven-point Likert-type scale, ranging from *Strongly*

Disagree to *Strongly Agree*. Example items include "After an argument, I feel very

lonely," "I often find that I don't live up to my own standards or ideals," and "Other

people have high expectations of me." The measure yields three factors: Dependency,

Self-Criticism, and Efficacy. Scores were calculated using the Reconstructed DEQ

method developed by Viglione and colleagues (1995), which used ten dependency items

and eleven self-criticism items that matched Blatt's theoretical concepts, and that showed

high and differential factor loadings in an exploratory factor analysis. The DEQ has good

reliability, with Cronbach's alphas of .81 for Dependency and .80 for Self-Criticism

(Zuroff & Fitzpatrick 1995). The measure has also shown good test-retest reliabilities for

5 and 13 weeks ($r = .89$ and $r = .81$, respectively; Lehman et al., 1997). The measure has

been used with Middle Eastern participants and has produced good internal reliability

(Abu-Kaf & Priel, 2012). An Arabic version of the measure is also available for use.

       State-Trait Anger Expression Inventory (STAXI-2; Spielberger, 2010). The

STAXI-2 represents the most widely used measure of anger in both clinical and research

settings (Novaco & Taylor, 2004). The measure contains 57-items and is scored on a

four-point Likert-type scale, ranging from *Almost Never* to *Almost Always*. The STAXI-2

assess State-Anger, Trait-Anger, and Anger-Expression. For the purposes of this study,

only the Trait Anger scale was utilized, which consisted of 32-items. The scale consists

of four subscales: *Anger Expression-out* (AX-O), *Anger Expression-In (AX-I), Anger*

Control-out (AC-O), and Anger-Control-in (AC-I), with eight items in each subscale.

The scale has shown good internal consistency with a Cronbach alpha of .88 in a sample

of male prison inmates (Etzler et al., 2014). Similarly, the four subscales have shown

good internal consistency with coefficient alphas ranging from .72 to .87 in samples of

White and Hispanic non-clinical male participants (Culhane & Morera, 2010). Finally,

the Anger Expression-In subscale has demonstrated acceptable internal consistency with

reliability alphas of .78 in non-clinical female populations (Spielberger, 2010). The

subscale also shows good construct validity as it is highly correlated with emotional

instability ($r =.25$) and optimistic recklessness ($r = -.26$; Etzler et al., 2014). The STAXI-

2 has been utilized with diverse populations, including Chinese (Bishop & Quah, 1998),

German (Müller et al., 2001), and Indian (Ghosh & Sharma, 2006). The original STAXI

(Spielberger, 1995) has been translated into Arabic and has produced good internal

consistency in a sample of Yemeni and Tunisian participants, with Cronbach's alphas

ranging from .79 to .81 (Nakajima et al., 2016).

Centrality of Religiosity Scale-15 (CRS-15; Huber & Huber, 2012). The CRS-

15 is a 15-item self-report measure assessing the importance and salience of religious

meanings in personality. This measure has been used in over a hundred sociology,

psychology, and religious studies in over 25 countries, and with over 1,000 subjects

(Huber & Huber, 2012). Borrowed from Glock's theory of multidimensional model of

religion (Babbie, 1973), the CRS-15 measures the intensity of the five theoretical defined

core dimensions of religiosity: public practice, private practice, religious experience,

ideology, and the intellectual dimension (Huber, & Huber, 2012). The total result

(Centrality) is the sum of the five subscales' results, with higher scores indicating higher

levels of religious centrality. This measure has shown good construct validity with other

measures of salience of religious identity and the importance of religion in daily life ($r =$

.66–.83; Huber & Huber, 2012). The CRS-15 has excellent internal consistency, with

Cronbach's alpha in the .92 and .96 range (Zarzycka, & Rydz, 2014). Example items

include, "How often do you take part in religious services?" and "How important is

personal prayer for you?" Frequency questions are scored on a five-point scale (*Very*

Often, Often, Occasionally, Rarely, Never); importance items are also scored on a five-

point scale (*Very Much, Quite a Bit, Moderately, Not Very Much, Not at All*).

Singelis Self Construal Scale (SCS; Singelis, 1994). The SCS is a 30-item self-

report questionnaire assessing independent and interdependent self construal.

Participants respond on a seven-point Likert-type scale, from *Disagree Strongly* to *Agree*

Strongly. For the purposes of this study, only the 12 items assessing interdependent self

construal were utilized. A mean score is calculated by adding each subject's scores (1 to

7) and dividing by 12. Interdependent example items include "I have respect for

authority figures with whom I interact," and "It is important for me to maintain harmony within my group." The SCS has demonstrated adequate internal reliability, construct validity, and predictive validity (Grace & Cramer, 2003). Factor loadings of .35 to .58 have been reported for the interdependent items. Acceptable Cronbach's alphas have been reported, ranging from .71 to .78 (Grace & Cramer, 2003). The measure was used in a Middle Eastern sample and produced a Cronbach's alpha of .78 for the interdependent scale. The SCS has shown construct validity given that the interdependent self construal subscale has often been found to be higher among participants from collectivist cultures (e.g., Singelis et al., 1999; Singelis & Brown, 1995).

Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992). The MEIM is a 12-item self-report measure designed to assess ethnic identity as a generalized phenomenon across ethnic groups in the United States (Phinney, 1992). The items of the measure are presented on a four-point Likert scale, with answers ranging from 4 (*Strongly Agree*) to 1 (*Strongly Disagree*). There are four reversed items to control for response bias. The measure has shown excellent internal consistency, with alphas ranging from .81 to .92 (Goodstein & Ponterotto, 1997; Phinney, 1992; Taub, 1995). The measure has also shown construct validity as it has been highly correlated with measures of acculturation (Cuellar et al., 1997), ethnic self-concept (Phinney et al., 1996), and multicultural orientation (Ponterotto et al., 2003). Example items include, "I have a clear sense of my ethnic background and what it means for me" and "I understand pretty well what my ethnic group membership means to me."

Procedure

Participants were recruited using multiple methods. Undergraduate and graduate students were recruited using the PEC program at Long Island University—Brooklyn Campus (LIU). LIU students were compensated via receiving PEC credits for their participation in the study. Additionally, participants were recruited from the community; specifically, IRB approved recruitment material was distributed electronically to various Middle Eastern and Arab community centers across the country. A "snowball" method of recruitment was also utilized to aid in the recruitment of the female Middle Eastern sample; specifically, participants who enrolled in the study were encouraged to refer family and friends who they believed would be eligible and interested in enrolling in the study. A live study link was emailed to all participants who meet the criteria for the study. Non-PEC participants who were interested in participating in a raffle were compensated through the chance of winning one of 20 $20 Amazon gift cards.

Prior to completing any study material, participants who met study eligibility signed an electronic IRB approved informed consent. Next, participants completed demographic information and all self-report measures using Qualtrics. Following the completion of the study, participants were debriefed about the goals of the project.

Statistical Analyses

Statistical analyses were performed using SPSS software and Hayes PROCESS Analysis (Hayes, 2017). Prior to hypothesis testing, preliminary statistical analyses were conducted to assess for skewness, kurtosis, and scedasticity. Reliability of the self-report measures were examined and are displayed in Table 1. An analysis of missing data was conducted, and subjects with data that were missing at random were excluded from the

Table 1.

Descriptive Statistics for Scales Examined in Preliminary Analyses

| Measure	*n*	Min.	Max.	*M*	*SD*	Skew	Kurtosis	Cronbach's α
BDI	188	21.00	80.00	35.86	11.54	1.21	1.37	.91
TOSCA-Shame	200	20.00	80.00	49.35	11.24	-0.01	0.02	.81
STAXI-Anger In	195	1.14	3.75	2.28	0.58	0.26	-0.70	.76
CRS	196	1.33	5.00	3.90	0.89	-1.05	0.55	.95
SCS-Interdependence	198	2.73	7.00	5.06	0.79	-0.03	-0.10	.74
MEIM	172	1.00	3.91	1.79	0.53	0.72	1.09	.90
ISS	195	24.00	120.00	55.06	22.91	0.74	-0.09	.97
DEQ-Dependency	188	22.00	69.00	49.17	9.09	-0.41	0.02	.73

Note. n sizes differ due to missing data. *M* = Mean; *SD* = Standard Deviation. BDI = Beck Depression Inventory-II (Beck et al., 1996); TOSCA-Shame = Shame subscale of the Test of Self-Conscious Affect-3 (Tangney et al., 2000); STAXI-Anger In = Anger Expression-In subscale of the State-Trait Anger Expression Inventory (Spielberger, 2010); CRS = Centrality of Religiosity Scale (Huber & Huber, 2012); SCS-Interdependence = Interdependent Self Construal subscale of Singelis's Self Construal Scale (Singelis, 1994); MEIM = Multigroup Ethnic Identity Measure (Gaines et al., 2013); ISS = Internalized Shame Scale (Cook, 2001); DEQ-Dependency = Dependency Scale of the Depression Experience Questionnaire (Blatt, 1974).

analysis. Significant outliers were also excluded from the analysis. A preliminary correlational analyses, ANOVAs, and independent *t*-tests were conducted to assess for any statistically significant covariates.

After conducting preliminary analysis testing for underlying univariate and multivariate assumptions, hypotheses testing was performed. The hypotheses were tested using a combination of mediation and moderated mediation models using the PROCESS bootstrapping procedures (Hayes, 2017) that only requires that covariates are controlled for if they are impacting the dependent, mediator, or moderator variables. Direct and indirect effects were computed by running a series of ordinary least squares regressions. Indirect effects were found based on the 95% confidence interval (CI) derived from 5,000 bootstrap resamples. A significant indirect effect was designated when the CI value did not include zero. It is important to note that PROCESS model generates a custom distribution and does not require the assumption of a normal distribution. Hypotheses 1 and 2 (a and b) were tested using Hayes mediation model 4 (Hayes, 2017). To test for a moderated mediation, with both direct and indirect effects, in hypothesis 3 (a and b), Hayes moderation model 8 was utilized (see Figure 1). Similarly, in order to assess for moderations and indirect effects in hypotheses, 4 (a and b) and 5 (a and b) Hayes moderation model 8 was utilized (Hayes, 2017). Plotting and probing of the interactions of moderations were conducted. Finally, exploratory questions were assessed using multiple regression analyses.

Figure 1.

The Mediated relationship between shame proneness and depression severity through anger suppression moderated by religiosity.
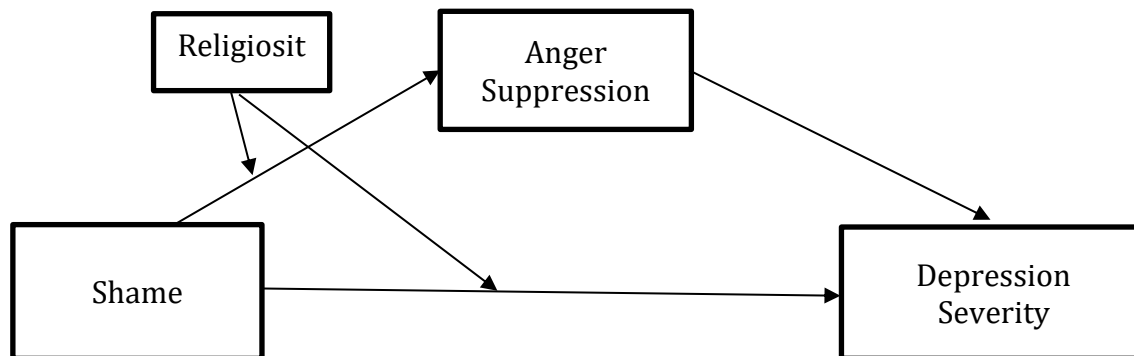
CHAPTER V

Results

Preliminary Analyses

Demographics. The final sample for this study consisted of 203 Middle Eastern

participants who identified as female. All participants were 18 or older and were

currently living in the United States. The sample ranged in terms of age, socioeconomic

status, and religious and cultural identification.   Demographic information is provided in

Table 2.

Missing Data. From a total of 213 completed surveys, ten were excluded from the

analyses due to failing at least two of four attention checks that were embedded in the

data, resulting in a total sample of 203 participants. Additionally, data from participants

who missed more than 10% of items for a single measure were also excluded when

computing the mean or sum of each particular measure. The number of excluded

participants based on that criterion ranged from 1.5% to 15.3%. Finally, when

calculating reliability analysis for each measure, participants who missed a single item on

a measure were excluded from the calculation of the Cronbach alpha for that particular

measure. This criterion resulted in missing data ranging from 6.4% for the SCS to 31.5%

for the BDI. An analysis of missing data was conducted for the BDI using little's MCAR

test, which was found to be significant, $p < 0.1$, failing to reject the null hypothesis that

data are missing completely at random. A closer analysis on an item level indicated that

the majority of the data were missing from item 21, *loss of interest in sex* (18.2%). Post

hoc analysis was conducted to assess the effects of omitting item 21 on the results. After

excluding the item and re-calculating the sum of the BDI, the measure continued to

Table 2.

Demographic Characteristics of Sample

Variable	*M(SD)*	*Min.*	*Max.*
Age	33.49 (10.85)	18	65

Variable	*n*	%
Family's Country of Origin		
Egypt	112	55.2%
Syria	24	11.8%
Lebanon	14	6.9%
Palestine	5	2.5%
Iraq	15	7.4%
Libya	1	0.5%
Jordan	3	1.5%
Iran	5	2.5%
Yemen	5	2.5%
Turkey	2	1.0%
Mixed	15	7.4%
Sexual Identity		
Heterosexual	117	87.2%
Lesbian	5	2.5%
Other	5	2.5%
Religious Identity		
Eastern Orthodox	73	36.0%
Christian	57	28.1%
Catholic	18	8.9%
Muslim	33	16.3%
Jewish	2	1.0%
Atheist	6	3.0%
Other	14	6.7%
Income		
Less than $3,999	1	0.5%
Between $4,000 and $12,999	7	3.4%
Between $13,000 and $19,999	5	2.5%
Between $20,000 and $34,999	11	5.4%
Between $35,000 and $54,999	19	9.4%
Between $55,000 and $76,999	35	17.2%
Between $77,000 and $97,999	23	11.3%
Between $98,000 and $149,999	28	13.8%
Above $150,000	74	36.5%

Note. $N = 203$. M = Mean; SD = Standard Deviation.

produce excellent reliability, with Cronbach alpha of .91. Missing data from this measure was reduced from 31.5% to 18.2%. Data were re-analyzed for all of the hypotheses using the recomputed BDI sum; however, this did not change the significance of any of the results, and thus statistic from the full BDI was utilized in this section. Possible implications and reasons for the missing data are explored in the Discussion section. Correlations between the scales are displayed in Table 3.

Covariates. Prior to data collection, age, socioeconomic status, and the participants' length of living in the United States were determined to have a possible impact on the dependent variables, depression severity, and dependency, and thus were examined as possible covariates. The impact of age was tested using Pearson's correlation coefficients. Due to the significant effect of age on the dependent variables, all hypotheses were tested while controlling for participants' age. The impact of the participants' income was assessed by conducting several one-way ANOVAs. See Table 4 for means and standard deviations. Due to the significant effect of income on the dependent variables, all hypotheses were tested while controlling for participants' income.

Given that age and income were significantly correlated, r (203) = .19, $p < .01$, post hoc stepwise regression analysis was conducted to assess the degree with which each of these variables predicts depression severity. Shame, income, and age were included as possible predictor variables. The overall model was found to be significant, $R^2 = .36$, $F(3,182) = 33.55$, $p < .001$. Income was found to be a significant negative predictor of depression severity, $b = -1.79$, $p < .001$, and independently explained 11.1% of the

Table 3.

Correlations of Variables Examined in Preliminary Analyses (N = 203)

Measure	1	2	3	4	5	6	7	8	9	10
1. BDI	—									
2. TOSCA-Shame	.48***	—								
3. STAXI-AXI	.68***	.42***	—							
4. CRS	-.21**	-.18*	-.23**	—						
5. SCS	.14	.29***	.15*	.08	—					
6. MEIM	.09	.14	.16*	-.15*	-.18*	—				
7. ISS	.78***	.56***	.65***	-.30***	.11	.16*	—			
8. DEQ-DEP	.43***	.44***	.37***	-.07	.46***	.01	.46***	—		
9. Age	-.31***	-.19**	-.28***	.28***	.02	.01	-.38***	-.19**	—	
10. Income	-.40***	-.13	-.29***	.09	-.08	-.06	-.35***	-.15*	.19**	—

Note. BDI = Beck Depression Inventory-II (Beck et al., 1996); TOSCA-Shame = Shame subscale of the Test of Self-Conscious Affect-3 (Tangney et al., 2000); STAXI-Anger In = Anger Expression-In subscale of the State-Trait Anger Expression Inventory (Spielberger, 2010); CRS = Centrality of Religiosity Scale (Huber & Huber, 2012); SCS-Interdependence = Interdependent Self Construal subscale of Singelis's Self Construal Scale (Singelis, 1994); MEIM = Multigroup Ethnic Identity Measure (Gaines et al., 2013); ISS = Internalized Shame Scale (Cook, 2001); DEQ-Dependency = Dependency Scale of the Depression Experience Questionnaire (Blatt, 1974).

*p < .05; **p < .01, ***p<.001

Table 4.

Means and Standard Deviations of Depression Severity as a Function of Income Level

		Inventory Score	
Income Level	*n*	*M*	*SD*
Less than $3,999	1	34.00	–
Between $4,000 and $12,999	6	50.80[a]	10.80
Between $13,000 and $19,999	5	56.98[c]	13.71
Between $20,000 and $34,999	10	42.71[e]	11.23
Between $35,000 and $54,999	18	36.28[h]	13.89
Between $55,000 and $76,999	33	40.48[d]	12.75
Between $77,000 and 97,999	20	31.33[g]	7.04
Between $98,000 and $149,999	27	30.76[f]	6.21
Above $150,000	68	33.0[b]	9.14

Note. $N = 203$. *M* = Mean; *SD* = Standard Deviation. Significant differences $p < .05$ noted [a] vs [b], [b] vs [c], [b] vs [d], [e] vs [f], [c] vs [f], [a] vs [f], [c] vs [g], [a] vs [g], [d] vs [g], [c] vs [d], [c] vs [h].

variance. After removing the effects of income, age continued to be a significant negative predictor of depression severity, $b = -0.16$, $p < .05$; however, it only explained an additional 1.8% of the variance; thus, income appears to play a more significant role in predicting depression severity compared to age.

Another possible covariate that was assessed was the participants' length of stay in the United States. In order to assess this variable, participants were first divided into two groups, US-born ($n = 111$) and non-US born ($n = 76$), using an independent samples t-test. Levene's Test indicated homogeneity of variances, so equal variances were assumed. There was no significant difference between the US-born participants ($M = 36.31$, $SD = 11.56$) and the non-US born participants ($M = 34.94$, $SD = 11.40$) in terms of depression severity, $t(185) = 0.80$, $p = .37$. Similarly, dependency was not found to be significantly different between the US-born participants ($M = 49.77$, $SD = 8.32$) and the non-US born participants ($M = 48.25$, $SD = 10.12$), $t(185) = 1.13$, $p = .06$. The second phase of assessing the effects of the participants' length of stay in the United States included temporarily removing the participants who were born in the United States in order to assess if there is a correlation between the duration of living in the United States for non-US born participants and depression severity and dependency. Results of the Pearson correlation showed no significant correlation between length of stay in the United States and depression severity, $r(73) = -.05$, $p = .70$, and no significant correlation between length of stay in the United States and dependency, $r(74) = .05$, $p = .66$.

Finally, in order to assess possible differences among dimensions of religiosity, post hoc Pearson's correlational analyses were conducted on the five dimensions of the

Centrality of Religiosity Scale: public practice, private practice, religious experience,
ideology, and intellectual dimension, which comprise the total centrality score. Private
practice was found to be significantly and negatively correlated with depression severity,
r (186) = -.23, $p < .01$, shame proneness, r (197) = -.16, $p < .05$, and anger suppression, r
(193) = -.25, $p < .01$. Public practice was also found to be significantly and negatively
correlated with depression severity, r (186) = -.24, $p < .01$, and anger suppression, r (193)
= -.16, $p < .05$. Finally, religious experience was found to be significantly and negatively
correlated with shame proneness, r (197) = -.14, $p < .05$, and anger suppression, r (193) =
-.23, $p < .01$.

Hypothesis Testing

All hypotheses were tested while controlling for the participants' age and income.

Hypothesis 1. **There would be a significant positive main effect of shame on
depression severity.** This hypothesis was tested using a mediation model (Model 4;
PROCESS V3; Hayes, 2017) that was also used to examine Hypothesis 2. The overall
model of shame predicting depression severity was found to be significant $R^2 = .54$,
$F(4,176) = 52.64$, $p <.001$. This model explained 54% of the variance in depression. As
hypothesized, shame proneness was found to be a significant predictor of depression
severity, $b = 0.23$, $t(176) = 3.89$, $p <.001$. Thus, this hypothesis was supported.

Hypothesis 2a. **There would be a significant positive main effect of shame on anger
suppression.** This hypothesis was tested using a mediation model (Model 4; PROCESS
V3; Hayes, 2017). The overall model of shame predicting anger suppression was found
to be significant, $R^2 = .27$, $F(3,177) = 22.02$, $p <.001$. This model explained 27% of the

variance in anger suppression. As hypothesized, shame was a significant predictor of anger suppression, $b = 0.02$, $t(177) = 5.04$, $p < .001$. Thus, this hypothesis was supported.

Hypothesis 2b. **Anger suppression would significantly mediate the relationship between shame on depression severity, such that there would be a significant positive indirect effect of shame on d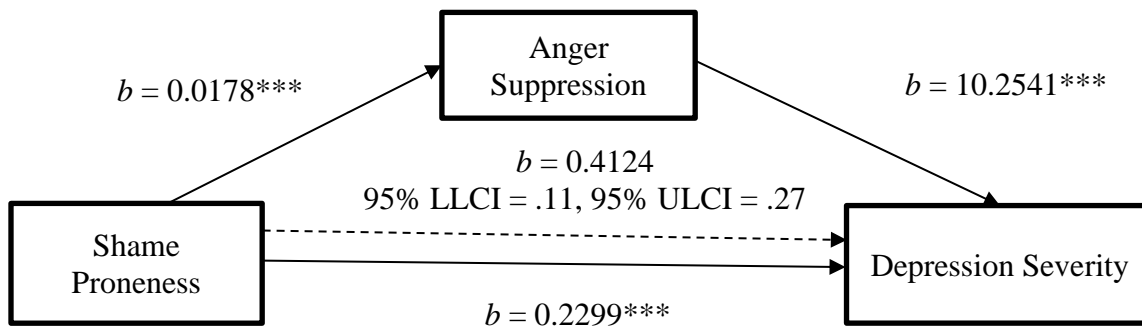epression severity through anger suppression.** Hayes mediation regression analysis was used (PROCESS V3; Model 4; Hayes, 2017). The indirect effect of shame on depression severity through anger suppression was significant, $b = 0.18$, $SE = .0420$, 95% LLCI = .11, 95% ULCI = .27. Similarly, the total effect of shame on depression severity was significant, after controlling for anger suppression, $b = 0.41$, $t(176) = 6.25$, $p < .001$. Thus, this hypothesis was supported and is displayed in Figure 2.

Hypothesis 3a. **Religiosity would moderate the relationship between shame and anger suppression, such that the relationship between shame and anger suppression would be significantly stronger and positive as religiosity increased.** This hypothesis was tested using a moderated mediation model (Model 8; PROCESS V3; Hayes, 2017). The overall model of the interaction between shame, anger suppression, and religiosity predicting depression severity was found to be significant, $R^2 = .54$, $F(6,171) = 33.74$, $p < .001$. However, degree of religiosity was not found to significantly moderate the relationship between shame proneness and anger suppression, $b = -0.003$, $t(171) = -0.66$, $p = .51$. Thus, this hypothesis was not supported.

Hypothesis 3b. **Religiosity would moderate i) the mediated relationship that anger suppression has between the relationship of shame and depression severity, such that the indirect effect of shame on depression severity through anger suppression**

Figure 2. Mediation model of the effect of shame proneness on depression severity mediated by anger suppression.

Note. $N = 180$. $R^2 = 0.54$. b = unstandardized coefficient. Dashed line = indirect effect; solid lines = direct effects.

*** $p < .001$.

would be significantly stronger and positive as religiosity increased and ii) the relationship between shame and depression severity, such that the direct effect of shame on depression severity would be significantly stronger and positive as religiosity increased. This hypothesis was tested using a moderated mediation model (Model 8; PROCESS V3; Hayes, 2017). Degree of religiosity did not significantly moderate the indirect effect of anger suppression on the relationship between shame proneness and depression severity, $b = 0.08$, $t(171) = 1.30$, $p = .19$, 95% LLCI = -.04, 95% ULCI = .20. The index of mediated moderation of shame and depression severity was also not significant, $b = -0.03$, $SE = .0428$, 95% LLCI = -.12, 95% ULCI = .06. Simple slopes are displayed in Figure 3. Similarly, degree of religiosity did not significantly moderate the direct effects of shame on depression severity, $b = -0.09$, $t(171) = -0.37$, $p = .71$, 95% LLCI = -.04, 95% ULCI = .20. Thus, this hypothesis was not supported.

Hypothesis 4a. **Interdependent self construal would moderate the relationship between shame and depression severity, such that the relationship between shame and depression would be significantly stronger and positive as interdependent self construal increased.** This hypothesis was tested using a moderated mediation model (Model 8; PROCESS V3; Hayes, 2017). The overall model of the interaction between shame, anger suppression, and interdependent self construal predicting depression severity was significant, $R^2 = .55$, $F(6,172) = 34.64$, $p < .001$. However, the interaction between interdependent self construal and shame proneness was not significant, indicating that interdependent self construal did not moderate the relationship between
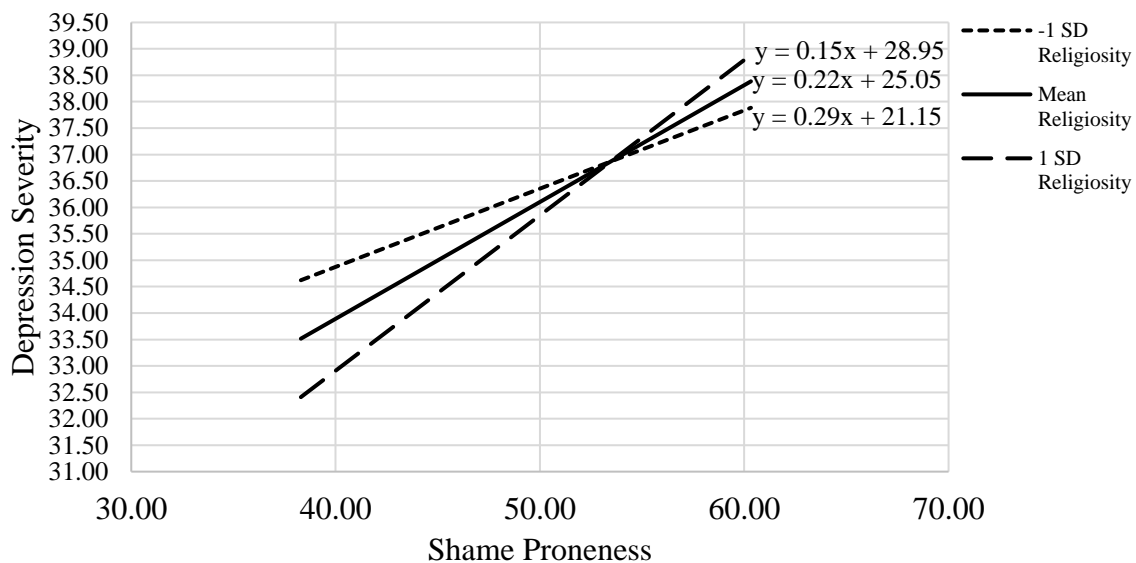
Figure 3. Simple slopes of shame proneness predicting depression severity for 1 *SD* below the mean of degree of religiosity, the mean of degree of religiosity, and 1 *SD* above the mean of degree of religiosity. $N = 178$. $R^2 = .54$, $F(6, 171) = 33.74$, $p < .001$. Interaction of shame proneness and religiosity on depression severity: $t(171) = 1.30$, $p = .19$.

shame proneness and depression severity, $t(172) = 1.49$, $b = 0.09$, $p = .14$. Thus, this

hypothesis was not supported.

Hypothesis 4b. **Interdependent self construal would moderate the mediated**

relationship that anger suppression has between the relationship of shame and

depression severity, such that the indirect effect of shame on depression severity

through anger suppression would be significantly stronger and positive as

interdependent self construal increased. This hypothesis was tested using a moderated

mediation model (Model 8; PROCESS V3; Hayes, 2017). Results indicated that

interdependent self construal did not moderate the indirect relationship of shame

proneness on depression severity through anger suppression, $t(172) = 1.49$, $b = 0.09$, p

$= .14$, 95% LLCI = -.03, 95% ULCI = .22. The index of mediated moderation of shame

and depression severity was also not significant, $b = 0.04$, $SE = .0380$, 95% LLCI = -.04,

95% ULCI = .11. All pairwise contrasts of conditional indirect effects from low (-1 *SD*)

to high (1 *SD*) interdependent self construal were not significant, as indicated by lower

level and upper level confidence intervals, and included the value zero, suggesting that

the null hypothesis could not be rejected. Pairwise contrasts are displayed in Table 5.

Hypothesis 5a. **Middle Eastern ethnic identity would moderate the relationship**

between shame and depression severity, such that the relationship between shame

and depression severity would be significantly stronger and positive as Middle

Eastern ethnic identity increased. This hypothesis was tested using a moderated

mediation model (Model 8; PROCESS V3; Hayes, 2017). The overall model of the

interaction between shame, anger suppression, and ethnic identity predicting depression

severity was significant, $R^2 = .51$, $F(6,152) = 26.48$, $p < .001$. However, the interaction

Table 5.

Pairwise Contrasts between Conditional Indirect Effects of Moderated Mediation Model with Interdependent Self Construal (N = 179)

Pair	Contrast	SE	LLCI	ULCI
Mean and -1 SD	0.30	0.32	-0.04	0.09
1 SD and -1 SD	0.06	0.64	-0.07	0.19
1 SD and Mean	0.03	0.33	-0.04	0.10

Note. Pairwise contrasts for -1 SD of Interdependent Self Construal, Mean Interdependent Self Construal, and 1 SD Interdependent Self Construal. SD = standard deviation; SE = standard error; LLCI = lower level confidence interval; ULCI = upper level confidence interval.

between shame proneness and ethnic identity in the prediction of depression severity was not found to be significant, indicating that ethnic identity did not moderate the relationship between shame proneness and depression severity, $t(152) = -1.16$, $b = -0.14$, $p = .25$. Thus, this hypothesis was not supported.

Hypothesis 5b. **Middle Eastern ethnic identity would moderate the mediated relationship that anger suppression has between the relationship of shame and depression severity, such that the indirect effect of shame on depression severity through anger suppression would be significantly stronger and positive as Middle Eastern ethnic identity increased.** This hypothesis was tested using a moderated mediation model (Model 8; PROCESS V3; Hayes, 2017). Results indicated that Middle Eastern ethnic identity did not moderate the indirect relationship of shame proneness on depression severity through anger suppression, $t(152) = -1.16$, $b = -0.14$, $p = .25$, 95% LLCI = -.38, 95% ULCI = .10. The index of mediated moderation of shame and depression severity was also not significant, $b = 0.04$, $SE = .0891$, 95% LLCI = -.14, 95% ULCI = .22. All pairwise contrasts of conditional indirect effects from low (-1 *SD*) to high (1 *SD*) Middle Eastern ethnic identity were not significant, as indicated by lower level and upper level confidence intervals, including the value zero. Thus, this hypothesis was not supported. Pairwise contrasts are displayed in Table 6.

Exploratory Research Questions

A simple linear regression was conducted to assess whether increased shame proneness predicted a higher degree of dependency. The overall model of shame proneness predicting dependency was found to be significant, $R^2 = .21$, $F(3,182) = 15.92$,

Table 6.

Pairwise Contrasts between Conditional Indirect Effects of Moderated Mediation Model with Ethnic Identity (N = 159)

Pair	Contrast	SE	LLCI	ULCI
Mean and -1 SD	0.02	0.47	-0.07	0.12
1 SD and -1 SD	0.41	0.09	-0.14	0.23
1 SD and Mean	0.02	0.47	-0.07	0.12

Note. Pairwise contrasts for -1 SD of Ethnic Identity, Mean Ethnic Identity, and 1 SD Ethnic Identity. SD = standard deviation; SE = standard error; LLCI = lower level confidence interval; ULCI = upper level confidence interval.

p <.001. This model explained 21% of the variance in dependency. Shame proneness

was found to be a significant predictor of dependency, *b* = 0.34, *t*(182) = 6.15, *p* <.001.

In order to assess if anger suppression explains the relationship between shame

proneness and dependency, a mediation model was used (Model 4; PROCESS V3;

Hayes, 2017). The overall model was found to be significant, R^2 = .24, *F*(4,174) = 13.55,

p <.001, explaining 24% of the variance in dependency. Shame proneness significantly

predicted anger suppression, *b* = 0.02, *t*(174) = 5.17, *p* <.001. Anger suppression also

significantly predicted dependency, *b* = 3.24, *t*(174) = 2.74, *p* <.005. Shame proneness

was found to have a significant direct effect on dependency, *b* = 0.28, *t*(174) = 4.72, *p*

<.001. The indirect effect of shame proneness on dependency, through anger

suppression, was also found to be significant, *b* = 0.06, SE = 0.03, 95% LLCI = .01, 95%

ULCI = .11. Finally, the total effect of shame proneness on dependency was significant,

t(174) = 6.03, *b* = 0.33, *p* <.001.

Finally, a simple linear regression was conducted in order to assess if internalized

shame predicts higher dependency. The overall model was found to be significant, R^2 =

.21, *F*(3,182) = 16.31, *p* <.001. This model explains 21% of the variance in dependency.

Internalized shame was found to be a significant predictor of higher dependency, *t*(182) =

5.92, *b* = 0.18, *p* <.001.

Results Summary

This study empirically investigated the role of shame proneness in predicting

depression severity, and examined several relevant factors, including anger suppression,

religiosity, interdependent self construal, and ethnic identity. Age and income were

identified as significant covariates and were controlled for in the analysis of all primary

hypotheses. Results of the primary analyses showed that shame proneness was a significant and positive predictor of depression severity. Additionally, shame proneness was found to significantly and positively predict anger suppression. Furthermore, anger suppression significantly mediated the relationship between shame proneness and depression severity. Conversely, religiosity did not significantly moderate the relationship between shame proneness and anger suppression. Additionally, utilizing a moderated mediation model, religiosity did not significantly moderate the direct or indirect effect of shame proneness on depression severity, through anger suppression. Interdependent self construal was also not a significant moderator in the relationship between shame proneness and depression severity, both in the presence and absence of the effects of anger suppression. Finally, ethnic identity did not significantly moderate the relationship between shame proneness and anger suppression, both in the presence and absence of the effects of anger suppression.

In terms of exploratory analyses, shame proneness significantly and positively predicted dependency. Furthermore, anger suppression was found to be a significant mediator in the relationship between shame proneness and dependency. Finally, internalized shame was also a significant predictor of dependency.

CHAPTER VI

Discussion

Shame has been the subject of study and interest for both psychoanalytic theorists (e.g., Freud, 1905; Lewis, 1971) as well contemporary researchers (e.g., Kim et al., 2011; Dearing & Tangney, 2011). Various theoretical models conceptualize shame as a reaction to criticism from others who observe one's transgressions (Bierbrauer, 1992) and tie it to attributing failures to an inherently defective self (Dost & Yagmurlu, 2008) and a global negative self-evaluation (Woien et al., 2003). It is thus not surprising that there is a robust link between shame and a plethora of psychopathology, including depression (e.g., Andrews et al., 2010; Kim et al., 2011; Schoenleber & Berenbaum, 2010). Additionally, studies have shown relevant sex differences relating to shame and depression, with women being significantly more likely to experience feelings of shame (Lewis, 1971) and depression compared with men (Wright et al., 1989). Moreover, although shame is a universal human emotion (Brown, 1991; Fessler, 2004; Tracy & Matsumoto, 2008), there is research to suggest cross-cultural differences in the frequency and expression of shame (Bierbrauer, 1992; Grey et al., 2018). Though limited, there is research to suggest more shame proneness in Middle Eastern cultures compared with Western cultures (Bierbrauer, 1992; Grey et al., 2018). This suggested difference is likely due to honor being a dominant value of the traditional social system in the Middle East (Fişek, 1993; Sunar & Aral, 1999). Additionally, the cultural push towards self-silencing (Ajrocuh, 2004; Kulwicki, 2002) is likely to lead to the inhibition of anger expression that results from the heightened shame experiences, which may explain the increase of depressive symptoms (Bridewell & Chang, 1997). Other relevant factors,

such as religiosity, interdependent self construal, and ethnic identity, have also been found to play important roles in the lives of Middle Eastern women and may lead to higher levels of depression among that population.

The goal of the current study was to investigate the role of shame proneness on depression severity in a sample of adult Middle Eastern women living in the United States. Specifically, the study aimed to replicate previous findings in other cultural groups that found a robust link between shame proneness and depression severity (Tangney et al., 1992). The study also explored several intrapsychic and cultural factors that were expected to have an impact on this suggested relationship between shame proneness and depression severity. First, the study examined whether anger suppression partially explained the relationship between shame proneness and depression severity. Further, the study investigated the role of religiosity, a factor that plays an integral role in the lives of most Middle Easterners, on shame, anger suppression, and depression. Specifically, the study predicted that a higher degree of religiosity would result in a stronger relationship between shame proneness and anger suppression. Additionally, the study predicted that the abovementioned relationship would further lead to an increase in depression severity. Finally, interdependent self construal and ethnic identity were expected to strengthen the relationship between shame proneness and depression severity, both in the presence and absence of anger suppression.

As expected, the results of this study showed that higher levels of shame proneness significantly predicted an increase in depression severity. Moreover, anger suppression did indeed partially explain the significant relationship between shame proneness and depression severity. However, the proposed cultural factors of religiosity,

interdependent self construal, and ethnic identity were not found to have a significant

moderating effect on the relationship between the variables mentioned above. The

present findings suggest that, in this sample of Middle Eastern women, shame proneness

and anger suppression were better predictors of depression severity compared to cultural

factors, including religiosity, interdependent self construal, and ethnic identity.

In the following sections, the significant relationship between shame proneness

and depression severity will be discussed, as well as interpretation regarding the role of

anger suppression in explaining this relationship. Exploration of the non-significant

results regarding the various cultural factors will also be reviewed. Next, study

limitations and directions for future research will be outlined. Finally, a brief review of

the current project's contributions to the literature and clinical implications will be

discussed.

The Shame-Depression Link

Consistent with expectations, participants who showed higher levels of shame

proneness were more likely to endorse more severe depressive symptoms compared with

participants who showed lower levels of shame proneness. These results match a robust

body of literature that delineates the negative impact of heightened feelings of shame and

its link to depression (Kim et al., 2011). Moreover, the results of this study add to the

scarce data available on the impact of shame proneness on mental health in Middle

Easterners. This finding is especially impactful given the emphasis Middle Eastern

culture places on the concepts of honor and shame (Ajrouch, 2004), and even more so on

women who are placed under more pressure to "preserve" family honor through

obedience and self-sacrifice (Ajrouch, 2004; Kulwicki, 2002). Qualitative research has

pointed to a failure to meet social obligations, giving in to sexual desires, and efforts of

individuation as the most common reasons for shame in Middle Eastern women (Sarı &

Gençöz, 2016). Thus, both a desire to break away as well as failure to meet social

obligations increases feelings of shame in Middle Eastern women. Arab women are often

expected to place the needs and desires of their family and culture above their own and

are socialized to be obedient and motherly (Stephan, 2006). Men, on the other hand,

have undertaken the "guardian" role, ensuring the chastity and purity of women in the

family (Fişek, 1993; Sunar & Aral, 1999). These expectations place different kinds of

pressure on women compared to men. Women who defy or fail to maintain the role of

the obedient and "pure" woman are led to feel shame, not only for their actions but also

for the shame they bring onto all other members of their family (Dwairy & Van Sickle,

1996). Consequences of engaging in behaviors that cause dishonor can be severe,

ranging from the loss of love and support of the family to physical violence, and in

extreme situations to "honor killings" (Abu-Rabia, 2011). Given this incredible amount

of pressure, and likely fear associated with the consequences of dishonor, the impact of

shame proneness in Arab culture and its significant connection to depression is of great

concern, though not surprising. The results of this study may then bridge the gap

between the high prevalence of shame proneness in Middle Eastern women (Grey et al.,

2018) and the high prevalence of depression among Middle Eastern women (Abu-Bader

et al., 2017; Okasha, 1999).

Shame Proneness and Anaclitic Depression. The dependency variable, or

anaclitic depression, acted in similar ways to depression severity, where shame proneness

was found to significantly predict dependency. This finding is consistent with the

theoretical support of a link between a field-dependent model of ego functioning (i.e., anaclitic depression) and shame (Lewis, 1971). The results suggest that individuals who are more prone to feelings of shame are significantly more likely to develop dependency characteristics, which are marked by feelings of loneliness, helplessness, and fear of abandonment (Blatt, 1995; Blatt & Homann, 1992a). Correlational analysis revealed a significant positive relationship between dependency and depression severity. Given that dependency was conceptualized by Blatt as a depressive style that is characterized by excessive interpersonal concerns, it follows that it would be related to a measure of depressive symptoms. However, despite the strong positive correlation between the two variables, they reflect different nuanced and distinct experiences of depression (Reis & Grenyer, 2002). In this project, depression severity, which was assessed using a symptom inventory, measured the participants' current state of distress, which is likely to vary at different points in time. Dependency, however, is reflective of an enduring personality structure that is not expected to range significantly from time to time. Additionally, while symptom inventories focus on overall current experiences of distress and their impact on one's functioning, dependency is more related to persistent interpersonal concerns and insecure attachment styles (Reis & Grenyer, 2002). Given this, the current significant results of shame proneness predicting dependency lend support to theories suggesting that individuals who are prone to feeling shame would be at higher risk of feelings of dependency, which are characterized by a fear of abandonment or rejection (Lewis, 1971). Thus, the results of this study indicate that Middle Eastern women who are more susceptible to feeling shame are also more likely to experience feelings of dependency. This finding is significant given that Arab women

are already in a position to be more dependent on their family and community compared to women from Western cultures (Bierbrauer, 1992; Sari & Gençöz, 2016).

Internalized Shame and Anaclitic Depression. Internalized shame was another exploratory variable which also acted in similar ways to the variable of shame proneness. Results showed that participants who reported higher experiences of internalized shame were more likely to report higher levels of dependency. There was also a strong positive correlation between shame proneness and internalized shame. Although the two constructs are closely related, there are suggested differences between them that are necessary to explore when studying shame. Specifically, in this study, shame proneness was assessed using the TOSCA-3 scale (Tangney et al., 2000). There are inconsistencies in the literature regarding whether this questionnaire measures state or trait shame (Giner-Sorolla et al., 2011; Goss et al., 1994). Therefore, in order to ensure that this study successfully captures trait shame, the Internalized Shame Scale (Cook, 2001) was also used to assess how frequently people experience shameful thoughts and feelings, which taps into trait shame. Based on this distinction, results from this project suggest that both trait shame was a significant predictor of dependency in Middle Eastern women. Thus, Middle Eastern women who have internalized feelings of shame, such as inadequacy and self-doubt, are more likely to have excessive interpersonal concerns such as fear of abandonment, helplessness, and loneliness. This finding is to be expected given that individuals who have a defective internalized sense of self are bound to have concerns about being helpless, ineffective, and insecure in their relationships.

One interesting observation that was noted when conducting the exploratory analysis of depression severity, assessed by the BDI (Beck et al., 1996), was the pattern

of missing data. Analysis revealed a significant amount of missing data (31.5%) that was not found to be missing at random. A closer examination of the pattern of missing data revealed that one item in particular, "*loss of interest in sex,*" was more likely to be left unanswered (18.2%) than any other item on the measure (0.5% - 6.9%). This observation mirrors results from a qualitative study that measured depression severity using the Arabic version of the Diagnostic Interview Schedule, where the participants reported that they found "*interest in sex less than usual?*" to be an inappropriate question (Matthey et al., 1997). This finding is reflective of the Middle East's general "unspoken" nature regarding sex, sexuality, and sexual suppression, especially among women (AbuKhalil, 1997; Stephan, 2006). Discussion about any sex-related topics remains a taboo and an "uncomfortable" topic of debate even among married Arab women who maintain, to a large extent, a silent and timid stance regarding this subject (Dialmy, 2005). It is therefore not surprising that a large percentage of the sample chose to leave this question unanswered. Ironically, the missing data regarding the women's experience of loss of interest in sex highlights the high degree of shame associated with sexuality in the Middle Eastern culture. This suggested association between shame and sexuality seems to only apply to women. Arab feminist writers have noted that women continue to be restricted when writing about sexuality, and the few who do are often accused of creating social chaos (Stephan, 2006). Thus, not surprisingly, to the best knowledge of the author of this study, there exists no quantitative data regarding the impact of sexual suppression on depressive symptoms in Middle Eastern women.

Age and Depression. Another notable finding from the exploratory analyses was the significant negative correlation between the participants' age and depression severity.

While age was expected to be a significant covariate, the relationship was predicted to be a positive one. That is, older participants were expected to report higher levels of depression severity (Stordal et al., 2003). Contrary to this prediction, results showed that as the age of the participants increased their report of depression severity decreased. Prior to data collection, a review of the literature pointed to age to be positively correlated with depression (Mirowsky & Ross, 1992; Stordal et al., 2003). Upon deeper exploration of other variables, age was also found to be negatively correlated with shame proneness, internalized shame, dependency, and anger suppression. The current findings may then indicate that there is something particular about this sample of Middle Eastern women that defies the above-mentioned common expectation.

Data from this project suggest that younger Middle Eastern women are more likely to endorse depressive symptoms compared to their older counterparts. One explanation for this finding could be that, unlike older women, younger Arab-American women may be under more pressure to conform to familial and cultural expectations and may face more scrutiny and more negative consequences if they were to fail to meet such expectations than their older counterparts. In fact, research suggests that, even from a young age, daughters are expected to maintain the well-being of the family and the safeguarding of its honor (Nasser-McMillian & Hakim-Larson, 2003). Studies on sexual abuse in Arab women suggest that heightened shame experiences are less tied to the physical act of the abuse itself and more tied to the implications the abuse has on the girl being perceived as undesirable, disgraceful, and "ruining" her family's reputation (Haboush & Alya, 2013). Young Arab women are often more concerned with issues related to sexual purity, modesty, and being a "good" girl, qualities that are

stereotypically sought after by Arab men in future wives (Hojat et al., 1999). Another added stressor that is likely to increase the risk of shame, anger suppression, and thus depression in younger compared with older Arab women, is the conflict between managing Arab traditions and Western modernization. Qualitative research has identified a wish to individuate as being a common factor that increases feelings of shame in Middle Eastern women (Sarı & Gençöz, 2016). Young Middle Eastern women may find themselves at a crossroad of attempting to fit into their host country's culture, which could result in losing the support of their community, or remaining dependent on their family, which may result in fewer opportunities to achieve self-actualization (Caldwell-Harris & Ayçiegi, 2006). These dilemmas are bound to increase feelings of anger in young Arab-American women, and as discussed earlier, this anger is likely to be suppressed in individuals who are more shame prone (Tangney et al., 1996). The amalgamation of these issues have been linked to the development of mental health issues, including depression, anxiety, and suicidal ideation (Hovey, 2000; Organista et al., 2003; Torres & Rollock, 2004), supporting the current findings.

Contrarily, the results of this project also suggest that, for this sample of Middle Eastern women, older age acted as a protective factor, meaning that the older the participants were, the less likely they were to experience feelings of shame, dependency, anger suppression, and depression. Exploring the role of other relevant demographic information helped explain the above-unexpected findings. One pertinent factor is the income of the study participants, which was also found to be a significant covariate. Specifically, the reported income of this sample of Middle Eastern women was significantly higher than the average US household income, with 36.5 percent of the

participants reporting a household income of $150,000 and above. Additionally, income was positively correlated with participants' age, meaning that as participants' age increased their reported household income also increased. Finally, higher income was also found to be negatively correlated with depression severity, dependency, internalized shame, and anger suppression. Taken together, these results suggest that as the participants' age increased, so did their income level, which acted as a buffer against feelings of depression, dependency, shame, and anger suppression. These results are logical given that older Middle Eastern women are less likely to strive for individuation (Ghaffarian, 1998) and that their behaviors are less monitored and scrutinized by their community, factors which are expected to increase feelings of shame in their younger counterparts. Additionally, the higher income earned by older Middle Eastern women is suspected to decrease a plethora of social and financial stressors, in turn decreasing reports of depressive symptoms. In addition to the robust shame-depression link discussed above, there are several factors that are thought to play an essential role in explaining this relationship, one of which is anger suppression.

The Role of Anger Suppression

Consistent with expectations, shame proneness was found to significantly predict anger suppression. That is, individuals who are more prone to feeling shame are also more likely to suppress their anger rather than express it. These results align with Tangney's theory that shame prone individuals place much emphasis on inhibiting their expression of socially unacceptable impulses, including anger (Tangney et al., 1992). When conceptualizing and interpreting these results through the experiences of Middle Eastern women, one could assume that many of the unreasonable cultural expectations

that intensify the women's shame proneness may increase their feelings of anger.

However, Middle Eastern cultural norms related to obedience and self-silencing

(Ajrocuh, 2004; Kulwicki, 2002) are likely to lead these women to inhibit their

expression of anger. Such a tendency towards anger suppression has been associated

with conflict avoidance, irritability, ruminations, higher levels of depression (Bridewell

& Chang, 1997; Martin & Dahlen, 2007) and lower levels of life satisfaction (Gross &

John, 2003). In fact, anger suppression has been found to be particularly higher among

depressed compared to non-depressed women (Dropplemann & Wilt, 1993; Jones et al.,

1992; Sperberg & Stabb, 1998).

Given this, as would be expected, anger suppression was found to significantly

explain the relationship between shame proneness and depression severity. This finding

supported the hypothesis that anger suppression plays an integral role in mediating the

robust relationship between individuals who are prone to feelings of shame and the

severity of sadness that they report experiencing. This is consistent with the theoretical

belief that when aggression and anger are not vented against the external world, they

become directed towards the self instead, resulting in pathological symptoms, including

depression (Alexander & French, 1948; Freud, 1936). In applying these findings to this

sample of Middle Eastern women, data from this study suggest that Middle Eastern

women who are prone to feelings of shame are more likely to experience depressive

symptoms, and that this relationship is in part impacted by their suppression of anger

following heightened shameful experiences. These results are poignant given the

suspected high prevalence of young Middle Eastern women who likely experience

chronic feelings of shame and anger suppression due to the pressures placed on them by

patriarchal cultural norms. The results highlight that when young Middle Eastern women are made to feel shame, which was discussed earlier to be a common experience given the high emphasis on honor and shame in the culture, they likely respond by restraining their expression of socially unacceptable impulses, including anger suppression (Tangney et al., 1992). This inhibition in expressing their anger is believed to contribute to an increase in depressive symptoms (Gross & John, 2003). Taken together, the results of this study bridge the gap between shame and depression and help explain the robustness of that relationship by accounting for the critical role of anger suppression among Middle Eastern women.

The exploratory question of whether anger suppression partially explains the relationship between shame proneness and dependency was also supported. This suggests that shame prone individuals show more dependency characteristics partially due to their tendency to suppress their anger. One plausible explanation can be made based on the theoretical belief that individuals who experience chronic feelings of shame tend to maintain a defective sense of self (Dost & Yagmurlu, 2008; Woien et al., 2003). It follows, then, that such individuals would approach relationships with a sense of insecurity and anxiety, including fear of abandonment and hypersensitivity to rejection, which are characteristics of a dependent personality structure (Blatt, 1995; Blatt & Homann, 1992a). Further, the results of this study suggest that anger suppression is a significant factor that helps explain the relationship between shame proneness and dependency. Specifically, one interpretation could be that women who experience a defective sense of self, due to chronic feelings of shame, suppress their anger to minimize causing any instability to their relationships, which in turn increases their sense of

dependency in the form of fear of abandonment and rejection sensitivity. This interpretation is derived from feminist theorists' beliefs that the nature of relationships that women engage in increases their proneness to depression, dependency (Chodorow, 1978; Gilligan et al., 1990), and suppression of feelings (Cox et al., 2000). Specifically, researchers have found that women tend to value connection with others over the expression of internal feelings, especially ones that may risk relationship stability (Cox et al., 2000). This suggests that women are more likely to suppress their anger in order to maintain their relationships, likely solidifying any anaclitic personality tendencies. These results may help illuminate some of the nuanced dynamics that play a role in increasing Middle Eastern women's sense of dependency. All three variables, shame proneness, anger suppression, and dependency, are significant elements that negatively impact the lives of most Middle Eastern women. These results are thus helpful in understanding the directionality and the ways by which women from Arab cultures become highly dependent. Given the high prevalence of shame in young Middle Eastern women (Grey et al., 2018), the results of this study indicate that the defective sense of self they may experience that result from feelings of shame may lead them to become more dependent, a reaction that is caused by a constant fear of losing important relationships due to their "defectiveness." Further, their efforts to suppress their anger, which is, in part, perpetuated by cultural expectations, plays an important role in the maintenance of dependency in their relationships. Another paramount factor that shapes the thoughts, feelings, and behaviors of Middle Eastern women is religiosity.

The Role of Religiosity

The research literature on religion and psychopathology is mixed (Chaaya et al., 2007). In this project, degree of religiosity was expected to strengthen the relationship between shame proneness and anger suppression; however, this hypothesis was not supported. Correlational analysis found degree of religiosity to be negatively correlated with depression severity, shame proneness, and anger suppression. This suggests that, in this sample of Middle Eastern women, religiosity acted as a protective factor against feelings of shame, depression, and anger suppression. These results conflict with research that has found the emphasis on sin in Judeo-Christian traditions to increase vulnerability to psychological maladjustment (Bierbrauer, 1992; Lester, 2012). One possible explanation that could clarify this discrepancy was offered by Luyten and colleagues (1998). They posited that, while religion in general, and Judeo-Christian belief in particular, emphasizes guilt and shame, there are other aspects of religiosity that provide means to buffer against the negative effects of shame and guilt (Luyten et al., 1998). Other studies have also suggested that religion can attenuate or even prevent the negative effects of shame and guilt (Pargament, 1996; Stack, 1992). For example, research has shown that religiosity can provide a sense of meaning, control, and self-esteem (Hood et al., 1996; Jacobs, 1992; Schumaker, 1992). The results also support data from other research studies that have found a positive relationship between spirituality and coping responses in adolescents and early adulthood (e.g., Krause et al., 2001; Young et al., 2000).

In order to attempt to resolve the contradictory results in the literature on this subject, a post hoc analysis was conducted to explore the nuanced aspects of religion

assessed by the Centrality of Religiosity Scale (Huber, 2003) and the variables of shame, depression, and anger suppression. The five dimensions of religiosity that are measured by the CRS-15 are Intellectual Dimension, Ideology, Public Practice, Private Practice, and Religious Experience. Correlational analysis revealed a negative and significant relationship between depression severity and the Public and Private Practice dimensions of the CRS-15. This finding indicates that, in this sample of Middle Eastern women, engaging in communal religious activities as well as individualized private rituals was significantly related to lower depressive symptoms. One interpretation could be that the social support and communal sense that are byproducts of being part of a congregation seem to decrease depressive symptoms in this sample of Middle Eastern women. Similarly, engaging in a relationship with God/a higher power in the form of private prayers and rituals also lessen reports of depression severity. These results highlight the importance of relationships and community for Middle Eastern women, both with God as well as with individuals with a similar belief system. Further exploration of the post hoc correlational analyses showed a significant negative relationship between shame proneness and the dimensions of Private Practice and Religious Experience. This suggests that a private relationship with God/higher power, in the form of prayers and a belief of a direct contact to an ultimate reality, decrease feelings of shame in Middle Eastern women. Additionally, anger suppression was found to be negatively correlated with Private and Public Practice, as well as Religious Experience. These findings further highlight the positive effects various aspects of religiosity have on the mental health of Middle Eastern women. The results of this project regarding the relationship between

religiosity and shame, depression, and anger suppression are especially important, given

the central role that religion plays in Arab culture (Amer & Hovey, 2007).

It is important to note that participants in this study reported affiliation with

stereotypically highly dogmatic religions, with 36 percent identifying as Eastern

Orthodox, 28 percent as Christian, 16 percent as Muslim, and 9 percent as Catholic.

Previous research had pointed to Orthodoxy as being a risk factor to psychological

maladjustment (Hutsebaut, 1996). Researchers posited that, while Orthodox individuals

may have positive God images, their relationship with God is colored by anxiety and

guilt. Additionally, Hutsebaut (1996) claimed that in Orthodoxy, individuals tend to

interpret the Bible in a literal manner, which can cause anxiety and uncertainty regarding

new and complex problems. Luyten and colleagues (1998) found a positive correlation

between Orthodoxy and depression and state anger. Again, these results are

contradictory to the findings of this study, which indicated a negative relationship

between religiosity, shame, depression, and anger suppression. Unlike previous research

findings, data from this study suggest that even among the most dogmatic of religions, a

high degree of religiosity in Middle Eastern women can act as a protective factor against

shame, depression, and anger suppression. One interpretation for these unexpected

findings may be that while in the general population certain aspects of religion may

increase messages of shame and guilt, leading to psychological maladjustment

(Bierbrauer, 1992; Hood, 1992; Lester, 2012), Middle Eastern women seem to rely on

religion as a way of coping with cultural stressors. For example, in the Coptic Orthodox

faith, believers are taught to abide by three statements that were often repeated by the late

Pope Shenouda III, "*this too will end soon*," "*God is here*," and "*all is for the good*."

Similarity, verses from the Quran, such as "Don't despair of God's mercy, for only the disbelievers get disappointed from God's mercy," and "He who trusts in God, God would be sufficient for him" teach messages of hope and trust (Hamidi et al., 2010). These statements, and other similar teachings, may work to comfort Middle Eastern women who may be at risk of distress due to societal and cultural pressures. Thus, data from this study suggests that Middle Eastern women do not perceive religious teachings and rules as another form of control over their thoughts and behaviors and instead view them as means of connecting with others, as well as with God, in order to deal with life stressors that are out of their control. In contrast, religiosity was found to be a predictor of depression among women living in the Middle East. For example, one study showed that high degree of religiosity was a significant predictor of postpartum depression in a sample of 137 women living in the United Emirates (Hamdan & Tamim, 2010). Similarly, another study that was conducted among 570 Egyptian nursing school students living in Cairo found a significant and positive correlation between religiosity and death depression (Al-Sabwah & Abdel-Khalek, 2006). The roles of other cultural elements, including interdependent self construal and ethnic identity, were also explored in this sample of Middle Eastern women.

Other Cultural Factors

Interdependent self construal, which views the self as inherently connected and meaningful through the relationship with others (Markus & Kitayama, 1991), was another factor that was predicted to strengthen the relationship between shame proneness and depression severity. However, the results of the study did not support this hypothesis. This finding suggests that individuals who define themselves in relation to

others and not as a separate self are less likely to report depressive symptoms compared

with individuals with lower interdependent self construal. Results from this study

contradict research literature that found interdependent self construal to predict

sociotropy, which often increases the risk of depression (Mak et al., 2011). Interestingly,

correlational analysis revealed a positive relationship between interdependent self

construal and shame and anger suppression, but not depression. This is consistent with

Dean and Fles's (2016) findings that the stronger the relationship between interdependent

self construal and shame was, the more strongly a person defined the self as

interconnected with others. They posited that individuals with an interdependent self

construal have worries about maintaining social bonds, which may trigger feelings of

shame in the face of transgressions. Taken together, the results of this study suggest that,

despite the significant and positive relationship between interdependent self construal and

anger suppression, interdependent self construal was not found to moderate the

relationship between shame and depression. One explanation to this finding may be that

the sense of connectedness that is often heightened in individuals with an interdependent

self construal, especially in a foreign country, decreases the risk of depression. Similar

results were found in a study that examined social support and its relation to depression

in a sample of older Korean immigrants (Roh, 2010). Consistent with findings from this

project, the study concluded that lower depression scores were related to higher levels of

religious and spiritual coping, greater social support, and higher income.

Separate but related, ethnic identity was also not found to be a meaningful

variable in strengthening the relationship between shame proneness and depression

severity. This indicates that individuals who strongly identify as Middle Eastern are not

more likely to report higher depressive symptoms as a result of shame proneness. Similarly, ethnic identity was not found to be significantly correlated with depression severity or shame proneness, further minimizing the role of ethnic identity in the shame-depression link. Results of recent studies on the differences between individuals who migrate versus those who choose to stay in their home country may partially explain the current finding. Six studies were conducted on 1,874 participants using different populations (Adam et al., 2018). Results indicated that living abroad leads to a clearer sense of self as it prompts self-reflection and forces one to analyze whether parts of their identity truly define them or if it is a mere reflection of cultural norms and expectations. This may suggest that the sense of ethnic identity felt by migrants may be inherently different from that experienced by individuals who choose not to migrate. In other words, an immigrant living in the United States, for example, may feel a strong sense of ethnic identity to the culture to which they belong and may continue to participate in some cultural practices; however, they may have a clearer sense of self that separates them from that culture.

Limitations and Future Directions

This study had a number of limitations. First and foremost, the sample in this project is not reflective of the general Arab-American population; thus, the results may be limited in their generalizability. Specifically, several demographic components are overrepresented in this Middle Eastern sample, including participants from high-income brackets, participants who identify as Egyptian, and participants who prescribe to the Christian faith. The sample's income, as expected, was higher than that of the US median income of $52,029 (Brittingham & de la Cruz, 2005). However, the income of

this sample was significantly higher than that of the median Arab American of $59,012,

with 42 percent of the sample reporting a household income between $55,000 and

$149,999 and 36.5 percent reporting an income above $150,000. Another factor is the

over-representation of Egyptians in this sample. According to recent census data,

Egyptians make-up approximately 11 percent of the Arab-American population (Arab

American Institute, 2011; Al-Romi, 2000; Nassar-McMillian & Hakim-Larson, 2003);

however, 55 percent of the participants in this project identified as Egyptians. Finally,

Christians were another group that was slightly over-represented in this sample, with 73

percent of participants identifying as Christian compared to 63 percent who identify as

Christian Arab Americans in the United States. Future studies should focus their

recruitment on a Middle Eastern sample that is more representative of the Arab American

population in terms of SES, country of ancestry, and religious affiliation. A more

accurate representation of Arab-Americans in terms of these criterion could enhance the

generalizability of the data and help in the detection of possible nuanced differences

among Middle Easterners.

A second limitation of this project is the lack of a comparison group. Data from

this study contributed to the research literature by replicating findings from studies

conducted in both Western as well as other collectivistic cultures. While the findings

help shed light on the nuanced experiences of Middle Eastern women living in the United

States and fills a number of gaps in the literature regarding this cultural group, the lack of

a comparison group constitutes a serious limitation. For example, it is believed that

comparing data collected from this study with data from Western women living in the

United States would have helped pinpoint specific risk factors that maybe only relevant

for one of the groups but not the other. Another critical group for comparison is Middle Eastern men. Investigating Middle Eastern men's reaction to shame, and comparing that to the reaction of women, could provide valuable clinical implications and guide psychotherapy approaches. Finally, while this study helped provide information regarding the experiences of Middle Eastern women living in the United States, collecting data from women in the Middle East would have certainly enriched the results of this project. The proposed comparison group would have been especially useful in understanding possible differences in shame reactions due to societal expectations between Middle Eastern women living in the Middle East and their counterparts who live in the United States. Future studies should assess whether there are meaningful differences between Arab American women and other groups, including Western women, Middle Eastern men, and Middle Eastern women living in the Middle East, as relating to shame proneness, anger suppression, and depression. Identifying the nuances of similarities and differences between these groups could help direct future research to take a deeper dive into intrapsychic aspects that are unique to particular cultures and genders, which would increase cultural competence in the practice of psychotherapy.

The mode of administration that was utilized in this study constitutes another critical limitation. First, the use of only English versions of the questionnaires may have been another shortfall of this study. While English fluency was one of the inclusion criteria for participation in this project, it is possible that information may have been lost in translation for some of the participants. Additionally, limiting participation for English-speaking Arab Americans likely impacted the representativeness of this sample, further impacting the generalizability of the results. This limitation may be challenging

to address since not all questionnaires were available in a validated and translated Arabic

version. Moreover, studies have found the process of translating assessments into

different languages to be labor-intensive, to require a lengthy amount of time, and to have

gaps relating to socio-cultural norms (Menon & Venkateswaran, 2017). Nevertheless,

countless studies have found that the mode of questionnaire administration, including

language, can have serious effects on data quality (Bowling, 2005; Wilson & Dewaele,

2010). Thus, future research should aim to provide participants from Middle Eastern

cultures with questionnaires in their preferred language. This adjustment may lead to the

increased participation of participants who are recent immigrants, from lower SES, and

ones who may be less acculturated to the American culture. This would likely

significantly enhance the representativeness and generalizability of the data.

A second notable issue that relates to the mode of administration is the fact that

all questionnaires were self-report measures. There are a number of advantages to

utilizing self-report measures, including ease of administration and efficiency; however,

there are reasons to believe that such a method of data collection may miss the extent of

distress experienced by Middle Easterners. Although scant, research has shown that

Middle Easterners tend to rely heavily on the defenses of somatization, repression, and

denial (Eloul et al., 2009; Okasha, 1999). More robust research from other collectivist

cultures has shown a similar trend in the use of these immature defensive styles (Chang et

al., 2010; Matsumoto, 2006). Due to heavy reliance on these defenses, psychological

disorders often go unnoticed, unreported, or misdiagnosed (Katon et al., 1982). In fact,

reporting psychiatric symptoms and seeking treatment among Middle Easterners is very

uncommon (Okasha, 1999). Mental illness is highly stigmatized among Middle

Easterners, as it is perceived as an individual weakness or a possible cause of shame to one's own family (Al-Darmaki, 2003; Al-Krenawi, 2005; Hijiawi et al., 2013). Due to the collectivist nature of Middle Eastern culture, social isolation resulting from mental illness stigmatization has been equated to death (Coker, 2005). Due to these reasons, it is possible that participants in this study may have underreported their depressive symptoms. Future studies assessing psychopathology in Middle Easterners should utilize not only explicit but also implicit measures in order to gain an accurate assessment of the participants' level of distress.

Contribution to the Literature and Clinical Implications

Despite the growing population of Arab Americans in the United States (Brittingham & de la Cruz, 2005), little is known about this population's psychological functioning. Several reasons were outlined earlier (see Literature Review section) regarding possible reasons for the scarcity of data among this population, including census categorization issues, stigma, and accessibility to mental health care. This study attempted to address some of these shortfalls by focusing on this specific cultural group, investigating prevailing societal factors that predict psychological maladjustment, with the hope that it will help guide clinical diagnoses and allow therapists to provide culturally informed psychotherapy.

The results of this study have shed light on various risk and protective factors that predict the severity of depression in Middle Eastern women living in the United States. Specifically, this project paid particular attention to the self-conscious emotion of shame, due to its high prevalence and the scarcity of quantitative data conducted among this cultural group on this topic (Grey et al., 2018). The findings replicated the

significant link between shame and depression that has been established in other collectivistic cultures (Fessler, 2004; Sznycer et al., 2012). Further, this project examined some relevant cultural and psychological factors that were thought to play a significant role in the link between shame and depression severity. The results helped highlight the negative impact of anger suppression, and the integral part it plays in predicting increased depressive symptoms, an area that has not been studied among Middle Eastern women. This finding is valuable given the suspected tendency for Arab women to suppress their anger, in order to comply with cultural norms, and the complete lack of quantitative data available regarding this issue. Moreover, this project was able to provide valuable information regarding the impact of shame and anger suppression on dependency. The study has also contributed to the literature by providing some clarity regarding the role of religiosity among this highly religious group, an area where research findings have been inconsistent (Chaaya et al., 2007). The data from this project show the positive impact religion can have in decreasing the severity of depression, anger suppression, and shame proneness among Middle Eastern women with stereotypically dogmatic religious affiliations.

The findings of this project have significant clinical implications that should be considered by psychotherapists and mental health professionals working with Middle Eastern clients. Specifically, therapists should become familiar with the significant prevalence of shame in Middle Eastern society and its possible impact on the clients' clinical presentation. Given the underlying defective sense of self of individuals who experience chronic feelings of shame (Dost & Yagmurlu, 2008; Woien et al., 2003), exploration and insight into these feelings could reduce levels of depression, anxiety,

substance abuse, and interpersonal difficulties that have been associated with chronic shame (Dearing & Tangney, 2011). Additionally, therapists should be aware of their Middle Eastern clients' possible tendencies to suppress their anger, both in and outside of therapy, and should give their clients a safe space to express their anger in more adaptive ways. Finally, the study's findings regarding the positive impact of religiosity on the mental health of Middle Eastern women allow psychotherapists to offer methods of reducing various life stressors. This is hopeful given the vital role religion plays in the lives of most Middle Easterners.

Conclusion

In summary, this project provided valuable information regarding the negative impact of shame proneness on the mental health of Middle Eastern women, a finding that has been found in other cultural groups (Bierbrauer, 1992; Grey et al., 2018). The results bridged the gap between the high prevalence of shame and depression among Middle Eastern women. Additionally, this study highlighted the role of anger suppression, an important explanatory variable, in the relationship between shame and depression. Further, the project revealed the significant effects of both state and trait shame in predicting anaclitic depression. Finally, the study clarified the positive impact of religiosity in attenuating depression severity in Middle Eastern women. All in all, the findings of this study underline risk and protective factors that contribute to the scarce literature on mental health in Middle Easterners and help inform diagnoses and psychotherapy for this growing population in the United States.

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Appendix A

List of Countries That Are Part of the Middle East

- Algeria
- Bahrain
- Egypt
- Iran
- Iraq
- Israel
- Jordan
- Kuwait
- Lebanon
- Libya
- Morocco
- Oman
- The Palestinian Territories
- Qatar
- Saudi Arabia
- Syria
- Tunisia
- Turkey
- United Arab Emirates
- Yemen