THE DIFFERENTIATION OF EMOTIONS OF SHAME AND GUILT IN ADOLESCENTS WITH MATERNAL BREAST CANCER

A THESIS SUBMITTED TO

THE GRADUATE SCHOOL OF SOCIAL SCIENCES

OF

MIDDLE EAST TECHNICAL UNIVERSITY

BY

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IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR

THE DEGREE OF MASTER OF SCIENCE

IN

THE DEPARTMENT OF PSYCHOLOGY

SEPTEMBER, 2011

Approval of the Graduate School of Social Sciences

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ABSTRACT

DIFFERENTIATION OF EMOTIONS OF GUILT AND SHAME IN THE ADOLESCENTS WITH MATERNAL BREAST CANCER

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September, 2011, 83 pages

This study aimed at revealing and differentiating the emotions of shame and guilt felt by the adolescents with maternal cancer. In order to reveal and differentiate these emotions, a sentence completion task and interviews were used. The study was conducted on 10 adolescents in age range of 16-20. With each participant, four private sessions were made. In the first session, the participant's knowledge of his/her mother's condition was evaluated through the Sentence Completion Test. In the second session, Pandora's Box, a film by Yeşim Ustaoğlu was watched with the participant to understand if the film evoked the targeted emotions and the second format of Sentence Completion Test was given. In the third session, 20 minute interviews were conducted with the participant, privately. These interviews were called "interventions" because they aimed to intervene to the process of feeling guilty and ashamed and replace them with a positive self-conscious emotion pride. The fourth and final session was conducted after one week and aimed to check if the anticipated affect of film and interventions lasted. Only 3 participants out of 10 returned for the fourth session, so the fourth session was left out of the analysis.

Two main analyses were conducted in the current study. The frequencies of shame and guilt were examined in the Sentence Completion Test analysis and the interviews were analysed qualitatively. The outcome resulted that in both

Sentence Completion Test and interview analysis, the adolescents with maternal cancer revealed emotions of shame and guilt. Furthermore, in the Sentence Completion Test analysis, it was tested whether the frequency of emotions of shame and guilt increased or decreased by the intervention of the film and interviews and the outcome yielded that neither the film Pandora's Box nor the interventions made any significant effect. The results were evaluated and the implications were discussed. Finally, limitations of the study and recommendations for future research were explained.
Keywords: Cancer, breast cancer, adolescents, self-conscious emotions, Cinematherapy, Interventions Technique, Qualitative Study.

ÖZ

ANNESİ KANSERLİ ERGENLERDEKİ SUÇLULUK VE UTANÇ DUYGULARININ BİRBİRİNDEN AYRIŞTIRILMASI

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Eylül, 2011, 83 sayfa

Bu çalışma, annesi kanser olmuş ergenlerdeki suçluluk ve utanç duygularını meydana çıkarma ve bu duyguların birbirinden ayrışıp ayrışmadığını incelemektedir. Bu duyguları ortaya çıkarmak için bir Cümle Tamamlama Testi ile Mülakatlar kullanılmıştır. Çalışma, yaşları 16-20 arasında değişen 10 katılımcıyla gerçekleştirilmiş, her katılımcıyla toplam 4 seans yapılmıştır. İlk seans tanışma seansı olup, katılımcının annesinin hastalığı hakkındaki bilgisi değerlendirilmiş, daha sonra Cümle Tamamlama Testi verilmiştir. İkinci seansta katılımcı ile araştırmacı Pandora'nın Kutusu adlı filmi izlemiş, ardından da Cümle Tamamlama Testi'nin ikinci versiyonu katılımcılara doldurulmuştur. Filmin kullanılmasındaki ana amaç, ergenlerdeki utanç ve suçluluk duygularınıfarkındalık düzeyine çıkartmaktır. Üçüncü seansta her katılımcıyla ve 20 dakika süren mülakatlar yapılmştır. Bu mülakatlara "müdahale" ismi verilmiş olup bunun nedeni ergenlerin hissettiği suçluluk ve utanç duygularının gurur duygusu ile değiştirilmesinin amaçlanmasıdır. Dördüncü ve son seans 1 hafta sonra gerçekleştirilmiş olup film ve mülakatların duygular üzerindeki etkisinin sürüp sürmediğini control edilmiştir. Son seansa, 10 katılımcıdan 3'ü katılmıştır.

Bu çalışmada iki analiz uygulanmıştır. İlki Cümle Tamamlama Testi ile ortaya çıkan suçluluk ve utanç duygularının frekans analizi olup ikincisi ise mülakatlarla yapılan kalitatif analizdir. Her iki analizin sonucunda da katılımcıların suçluluk ve utanç duygularını hissettiklerini belirtmişler ve bu duyguların birbirinden ayrıştırılabildiği ortaya çıkmıştır. Ayrıca, filmin ve mülakatların suçluluk ve utanç duygularını arttırıp arttırmadığı ve bu duygu frekanslarının seanslar arasında değişip değişmediğine de bakılmış olup, hem filmin hem de mülakatların sonuçlar üzerinde anlamlı bir etkisinin olmadığı anlaşılmıştır. Araştırmanın sonuçları yorumlanmış, sınırlılıkları ve diğer araştırmalar için öneriler sıralanmış ve açıklanmıştır.
Anahtar Kelimeler: Kanser, göğüs kanseri, ergen, suçluluk, utanç, Sinematerapi, Müdahale Tekniği, Kalitatif Çalışma

To my family.

ACKNOWLEDGEMENTS

First, I would like to thank my supervisor Prof. Dr. Faruk Gençöz, who challenged me with new ideas and supported me from beginning to the end. Without his support I would never have the courage to begin and complete my work.

I also would like to thank my committee members for their valuable comments and suggestions.

In addition I would like to offer my gratitude to Doç. Dr. Derya İren Akbıyık, who also is the originator of this thesis and supported me greatly through the data collection process. Working with her in Oncology Service was an amazing experience and I've learned so much. Her support through my hard and lonely days in Ankara meant so much to me.

I would like to express my thanks to very special people in my life for supporting me through my education and my graduate study. My mother, Sevgi Kaçmaz, my father, Mehmet Kaçmaz, my sisters Gül and Zeynep Kaçmaz, and my brother Gökçe Kaçmaz, I cannot thank you enough for supporting me for every day of my life, challenging me with new ideas and sheltering me with your love.

I am grateful that Deniz Şimşek was with me this whole time. He never let me lose hope and patiently endured my mood swings. I am very lucky that we found each other, that we learned so much from each other, grew up together, and we are together.

My dear friends and colleagues Duygu Arar, Çiğdem Vaizoğlu who were by my side in times that I was close giving up, Özge Ünal who helped me greatly through the data collecting process; I am really greatful to you girls, for being with me for the best and for the worst and for the times I thought I had no place to sleep.

I am grateful to my dear room mate Kıvılcım Uçar Alınmış, with whom the dark days were brighter; sharing everything with her was a privilege. I also would like to thank Fatih Cemil Kavcıoğlu who supported me greatly through this process. He literally gave me food and he gave me shelter, he became a very good friend.

Last, but not the least I would like to thank my dearest friend and colleague Erhan Okşak for making me remember my "axis" at a time I was lost. I am grateful that he became my mentor through the hard process of writing.

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CHAPTER 1

INTRODUCTION

"An individual doesn't get cancer, a family does" -Terry Tempest Williams.

1.1 Cancer

Cancer is an illness that significantly affects the individual patient- less apparent is the concomitant influence on the patient's family, particularly when children are involved. A diagnosis of cancer in a parent has been associated with significant negative emotional and behavioural issues for his or her children (Armistead et al., 1995; Armsden & Lewis, 1994; Compas et al., 1994; Hoke, 1997 and Worsham et al., 1997).

According to WHO (World Health Organisation), annually, around 10 million people worldwide will be diagnosed with cancer and a total of 22 million people are currently cancer patients. Since 1990, global cancer incidence has risen by 19%. Worldwide cancer rates are set to increase by as much as 50% by the year 2020 unless further preventative measures are put into practice. (John & Howars, 2005).

The cancer incidence in Turkey, which was 19.7/100,000 in 1983 increased to 60.6 /100,000 in 2001. An outstanding increase was noted in the Aegean Region. The incidence in the Aegean Region, which was noted as 24/100,000 in 1983, increased by the time and reached up to 111.2/100,000 in 2001. Cancer incidence was relatively low in the South-eastern and Black Sea

Regions when compared to the entire country (Yardım, Mollahaliloğlu & Çakır, 2007).

Yearly changes in the cancer incidence were noted in Turkey. According to data for the year 2001, cancer incidence was noted as 60.5/100,000 in general, which were 70.1/100,000 in male and 50.7/100,000 in female. When standardized by the European population, then it was found out to be 95.1/100,000. No regular trend is available with respect to the cancer incidence in Turkey due to the lack of information about cancer patients and facilities to set a solid record (Yardım, Mollahaliloğlu & Çakır, 2007).

1.1.1 Psychological Theories on Cancer

1.1.1.1 Psychosomatic Aspects

The notion that mind or emotions somehow are related to cancer is both old and new. During the 1950's and 1960's cancer was discussed as another psychosomatic disease caused by personality development or specific emotional distress (Surawicz et. al, 1978). But recently, the relationship between psychological defences and immunological functions including stress factors and environmental conditions has become the focus of psychosomatic research (Lipowski, 1977; Mason, 1978).

Tarlou and Smallheiser (1951) composed a research based on women with breast and cervix cancer, using Rorschach, Figure Drawing and an interview directed at psychosexual adjustment. Both groups of women manifested immature sexual identification and it is revealed that those with oral conflicts were more likely to develop breast cancer. Reznikoff (1955) conducted a research using TAT, Sentence Completion and Murray's Family Relation and

Childhood Memories Questionnaire. The results showed that maternal domination led to psychosexual maladjustment among precancerous factors in women who developed breast cancer. Bahnson and Bahnson (1969) proposed that denial and repression were the central dynamics in cancer.

Grinker (1966), supported a field theory approach to cancer aetiology constitutional and hereditary factors interacted with personality factors and stress-including life experiences. Cancer patients in this hypothesis most likely ceased to grow psychologically, somatically , or behaviourally. Grinker's hypothesis simply suggests that the modern nations' disease cancer is both psychological and somatic. According to the research, stress and depression may reduce the antibody response and that adult immunological responsivity may be a function of early infantile experiences (Bahnsen & Kissen, 1966, Rasmussen, 1966, Solomon, 1977).

1.1.1.2 Stress Theory

The relation between stress and cancer has recently been reviewed especially since two Nobel Prize winning scientists Marshall and Warren (2005) discovered the Helicobacter Pylori-Peptic Ulser connection. This discovery led the strongest "stress leading to cancer assumption" to extinct. Despite this discovery, scientists are still analyzing whether stress-cancer relation is nothing but a dogma (Arıkan, 2005).

Research made on this very subject have two different aspects of stress factor on the impact of cancer. First one is stress as the etiological factor and the second one is stress as the cause of relapse. For both aspects it is said for many

years that stress has a secondary role in cancer malformation. Which means that the disease has a genetic background but obviously stress factor triggers the genetic duration (Arıkan, 2007).

According to Glaser and Glaser (1985), stress damages the DNA structure and Spiegel et. al (1989) suggested that after the surgery of patients with breast cancer, reducing the stress and teaching the patient how to cope with stress reduced the number of relapse therefore prolonged the life time. But when Goldwin (2001) replicated the same research the results yielded differently and negatively (Arıkan, 2007).

Since 2000s, the importance of the effect of stress on cancer formation decreased and research focused on evolutionary and genetics of cancer cells. In patient histories stressful events are noticeable but it is a mystery that not every person who suffers from stressful events grows cancer. Since the results of research are ambiguous the real danger would be to exclude the stress factor altogether. (Arıkan, 2007).

1.1.2. Impact of Maternal Cancer on Adolescents

Each year almost 200.000 women are diagnosed with cancer, have adolescent children (Jemal et. al., 2009). Although the effect of cancer on women and their spouses has been well researched (Hoskins & Haber, 2000; Lewis, Hammond, & Woods, 1993; Northouse et. al., 1998; Pasacreta, McCorkle, & Margolis, 1990), research that focus on how adolescent children cope with their mothers' illness is an area which is just starting to emerge (Edwards et. al., 2008; Kristjanson, Chalmers, & Woodgate, 2004; Lewis, 2004).

When a family experiences maternal cancer, it should be remembered that each of these mothers is interpersonally linked with friends, family members, and loved ones, and that each of these individuals may be affected in turn by the patient's illness. Numerous spouses, partners, and children at some point must face the reality of coping with the diagnosis, treatment, and in some cases death of a mother with cancer (Altschuler et al., 1999; Armsden & Lewis, 1993; Worsham et al. 1997). Given the prevalence of cancer in Turkey and the resultant number of individuals that it touches, there is a pressing need for research that focuses on the impact that a parental cancer diagnosis has on the children in these families.

Great amount of recent studies has focused on the experience of the cancer patient herself and occasionally on the patient's romantic partner and spouse. The need for additional studies focusing on the ways of coping for children of a mother who has cancer has been suggested by multiple researchers (Altschuler, Dale, & Sass-Booth, 1999; Armsden & Lewis, 1993; Armsden & Lewis, 1994; Armistead, Klein, & Forehand, 1995; Birenbaum, Yancey, Phillips, Chand, & Huster, 1999; Compas et al., 1994; Graham & George, 1972; Lewis, Ellison, & Woods, 1985; Lewis, 1986; Lewis, Hammond, & Woods; 1993; Worsham, Compas &Ey, 1997).

Lewis and Hammond's (1996) investigation of the family's coping with breast cancer suggests that the illness of a parent impacts the amount of difficulties experienced in their family. For example, depression in mothers, negative marital appraisal by fathers, and poorer quality of parenting for adolescents. Wellisch (1979) and Wellisch, Gritz, Schain, Wang, and Siau

(1992), have investigated the potential link between parental cancer and the impact on children. Wellisch (1979) utilized six case studies of adolescents at different times in the illness of the parent; results highlighted the involvement of the adolescent and concomitant impact of the parent's cancer diagnosis. Wellisch et al. (1992) used structured interviews and surveys to examine the characteristics of children coping with parental cancer that may ameliorate or exacerbate the impact of parental illness.

Salient point in the literature is that adolescents experience "fear". They fear that their parent would die (Grandstaff, 1976; Lewis et.al, 2000; Hilton & Elfert, 1996; Hilton & Gustavson, 2002). When these adolescents were told that their parent was not going to die, they felt relieved (Hilton & Gustavson, 2002). Female adolescents whose mothers have breast cancer felt increased vulnerability to cancer because of the genetic risk which naturally caused fear which was associated with physical/sexual development (Grandstaff, 1976; Wellisch et., al., 1991; Spira & Kenemore, 2000; Kristjanson, Chalmers, &Woodgate, 2004). Males felt anxious about their parent's illness but felt unable to express their feelings and discuss their fears with either parents (Nelson et. al, 1994). Research reveals that adolescents conceal their thoughts, emotions and feeling in an attempt to protect their parent and not to cause tension in the relationship. They try to continue their life as if nothing has changed (Davey et.al, 2003). Although Spira and Kenemore (2002) suggest that fear of death of a parent and not being able to express the feeling may cause somatic symptoms in those adolescents, Davey et. al, (2005) reported that

adolescents tried to maintain positive thinking and attitudes, talked about cancer and relied on faith to relieve fear, sadness and anger.

According to Heiney et. Al (1997), adolescents with maternal cancer, informed significantly higher stait and trait anxiety compared to an age-normed sample. Lewis and Darby (2003) noted that when adolescents have poorer relationships with both parent, they showed lower self-esteem and increased anxiety.

Adolescent females whose mothers had cancer were significantly distressed

(Welch, Wadsworth, & Compass, 1996; Compas, Worsham, & Epping-Jordan, 1994; Grant, & Compass, 1995; Nelson, & While, 2002; Huizinga, Visser & Van der Graff, 2005; Visser, Huizinga, & Hoekstra, 2005). According to Watson et al. (2006) maternal depression combined with poorly defined family roles increased the danger of internalizing problems, especially in females. According to Welch et al. (1996), adolescents' self-reported symptoms of anxiety/ depression did not vary according to type of parental cancer. Thus, adolescents whose mothers had breast cancer were no more likely to experience higher levels of anxiety/depression than adolescents whose mothers had other types of cancer.

According to Lewis and Darby (2003) adolescents tended to show increased behavioural problems when both parents had depressed mood; maternal depressed mood was the main source of influence. Males reported that parental illness had affected their schoolwork and amount of leisure time for sports and activities with friends.

Lewis' (1996) correlational analyses between the mother's illness-related demands and the adolescent's functioning revealed that the greater the number of family-related illness demands the mother experienced, the greater the number of behavioural problems reported by the adolescent.

Research made on the impact of maternal cancer on adolescents, brought light into many issues. It is obvious that these adolescents feel fear of loss, sadness, anger and anxiety when their mother has cancer. They also experience difficulties in their schools, they have serious school work problems because of what is happening inside their home. It is revealed that these adolescents also go through behavioural problems in the family and in their social environment. To sum up, these research present that these adolescents experience emotions that they could not deal by themselves and the lack of ability to cope with the mothers' illness cause problems in their school and social environment.

Research also brought light that fear of loss, sadness, anger and anxiety these adolescents experience are the emotions that exist on the surface. Although working with these emotions is significantly important and beneficial, it is also crucial to understand the emotions beneath the surface. Therefore, self-conscious emotions like shame, guilt and pride these adolescents experience should also be searched.

1.2. Self-conscious Emotions

The emotions did not find a place in psychology literature until the last quarter of the 20 th century despite their important position in human life. Although the significance of emotions was realized rather late, the importance that they deserved was granted in an explicit and detailed way. As a result, the place of emotions and how they affect human life may be explained.

Different approaches attribute different meanings to emotional processes. For example, psychodynamic approach views emotions as a product of diverted psychic energy, which can take the form of neurotic symptoms. According to that view, malfunction of a person is the result of frustrated emotions and inadequate discharge of psychic energy. On the other hand, behavioural approach suggests that emotions are learned responses. Accordingly, it is stated that dysfunction is seen as the result of lacking in skills or the conditioning of undesirable responses. What cognitive approach proposes is that dysfunction is caused by distorted cognitions. The cognitive processes such as attributions influence emotions. Lastly, according to the humanistic and experimental approaches, emotions are valuable source of information that guides an individual's experience. Dysfunction occurs when person denies, suppresses or interrupts emotional experiences (Tangley & Dearing, 2002).

The term “self-conscious emotions” is originally defined by Michael Lewis (1988) who uses this term to mention guilt, shame, pride and their many possible variations. According to Lewis and his colleagues (1989), self-conscious emotions engage appraisal of oneself regarding some contextual or comprehensive criteria (Lewis, Sullivan, Stanger, & Weiss, 1989). Self-conscious emotions differ from the other emotions because they require self-evaluation which motivates the person to act in a socially appropriate way (Tangley & Dearing, 2002).

1.2.1. Self- conscious Emotions in Fundamental Approaches on Emotions

Self-conscious emotions are the feelings which the individual feels as a result of social comparison about one’s situation. These emotions (i.e. shame, guilt and pride) are defined as more complex compared to basic emotions (e.g. anger, sadness, joy, fear, disgust, and surprise). This is due to the fact that self-conscious emotions are based on social concern; they are not automatized like basic emotions forces by survival motive (Johnson-Laird & Oatley, 1989). In order for the individual to experience self-emotions, a cognitive process where there is social comparison is needed (Oatley & Johnson-Laird, 1987).

Table 1: Script for Pride, Shame and Guilt (Tangney and Fischer, 1995)

Emotion	Appraisal	Internal Reaction and Bodily Experience	Motive-action Tendency
Pride	Self is responsible for a socially valued outcome or for being socially valued person	Increase in the heart rate and skin conductance, erratic respiration. Body experienced as taller, stronger, or bigger.	Show worthy self to other, smile broadly, stand erect, make celebratory gestures, and call attention to accomplishments
Shame	Self has fallen short of standards of worth in the eyes of others	Blushing diminished heart rate. Body experienced as heavy or small	Hide the self, avert gaze, burry face in hands
Guilt	Self is responsible for a wrong doing	Increase heart rate. Body experienced as heavy	Fix situation correct wrongdoing, apologize, confess, make reparations, seek forgiveness

These kinds of emotions motivate and regulate people's thoughts, feelings and behaviours in more socially appropriate ways (Campos, Campos & Bartnett, 1989); Fischer & Tangney, 1995). Because of their internal standards, people feel shame and guilt while making evaluations of the situation in terms of their social positions. According to a view, the main function of these emotions is to help the individual get socialized by regulating his/her thoughts and behaviours (Campos, Mumme, Kermoian, & Campos, 1994).

Unlike basic emotions, self-conscious emotions display weaker evidence of universality because their antecedent, phenomenological experience and consequences differ across cultures (Kitayama, Markus & Matsumoto, 1995; Eid & Deiner, 2001). Moreover there is less evidence that they have pan-culturally recognized facial expressions. (Ekman, 1992). In addition, self-conscious emotions are subsumed by basic emotions in linguistic hierarchical classifications. For example sadness subsumes shame, joy subsumes pride. It is difficult to distinguish whether people feel sad or ashamed or joyful or proud for that matter.

The emergence of self-conscious emotions is observed later than that of basic emotions (Izard, 1971). Self-conscious emotions do not develop until around 18-23 months just like self-awareness. In fact, some theorists claim that they emerge at the age of three (Abe & Izard, 1999; Lewis, 1995). Later development of self-conscious emotions may be the result of the incomplete neurobiological development or rather psychosocial development to understand social rules and standards for appropriate behaviours (Tracy & Robins, 2004).

Table 2: A model of emotional development (Tracy, Robins and Tangney, 2007)

Self and self-conscious	Age of acquisition
Surprise, interest, joy, anger, sadness, fear, disgust	6 Months

Embarrassment (non-evaluative), envy, Empathy. Consciousness, as in self-referential behaviour	1 Year
Embarrassment (evaluative), pride, shame ,guilt	3 Years

Consciousness is required for understanding social rules and behaving appropriately. Since Freud wrote about "unconscious guilt", the psychoanalytic interpretation of emotion raised the question of whether a self-conscious emotion could be unconscious. This means, could an individual experience an evaluative emotion and not be aware of it. In the Unconscious (1915), he wrote "It is surely of the essence of an emotion that it should enter consciousness. So for emotion, feelings, and affects to be unconscious would be out of question. But in psychoanalytic practice we are accustomed to speak of unconscious love, hate, anger, etc., and find it impossible to avoid even the strange conjunction, "unconscious consciousness of guilt. .....Strictly speaking there are no unconscious affects in the sense in which there are unconscious ideas" (p.110). He finally concluded that the evaluation of an event can be unconscious even though the response process is not.

1.2.2 Shame and Guilt

Shame and guilt are rich human emotions that serve important functions at both the individual and relationship levels. One the one hand, as moral

emotions, shame and guilt are among our most private, intimate experiences. When self faces with transgression or error, it turns toward itself and starts judging. Thus, the experience of shame and guilt can guide our behaviour and influence who we are in our own eyes. (Tangney & Dearing, 2002). On the other hand, shame and guilt are inextricably in linked to the self in relationship with others. These emotions develop from our earliest interpersonal experiences and they develop in the family and in other key relationships. And throughout the lifespan, these emotions form a profound and continued influence on our behaviour in interpersonal contexts. Shame and guilt are thus both "self-conscious" and "moral" emotions: self-conscious in that they involve the self-evaluating the self and moral in that they presumably play a key role in fostering moral behaviour.

Shame is an extremely painful and ugly feeling that has a negative impact on interpersonal behaviour. Shame-prone individuals appear relatively more likely to blame others (as well as themselves) for negative events, more prone to a seething, bitter, resentful kind of anger and hostility, and less able to empathize with others in general. Guilt, on the other hand, may not be as bad as shame. Guilt-prone individuals appear better able to empathize with others and to accept responsibility for negative interpersonal events. They are relatively less prone to anger than their shame-prone peers. But when angry, these individuals appear more likely to express their anger in a fairly direct manner. This is an intriguing pattern, and it is the aspect of shame and guilt that has the most direct applied implications (Tangney & Dearing, 2002)

1.3. Assessing Shame and Guilt

1.3.1. Problems Distinguishing Between Shame and Guilt

Although shame and guilt are similar in that they are both considered selfconscious or social emotions, many theorists and researchers have further attempted to distinguish between the two emotions. Early researchers writing on shame and guilt attempted to make a distinction based on the kinds of situations that elicit shame or guilt (Benedict, 1946). One popular but possibly misguided idea was the "*public/private*" distinction, where shame was defined as dependent on public exposure of one's weakness or failure, whereas guilt's experience could be expected when the wrongdoing was a secret known only to the transgressor (Gehm & Scherer, 1988). A second distinction is the "*nonmoral/moral*" distinction. In this view, shame occurs after violating non-moral standards (e.g., test failure), whereas guilt arises after a moral standard violation (Ausubel, 1955; Erikson, 1959/1994). Importantly, these two distinctions have received little empirical support. Both shame and guilt have been found to be elicited more frequently in a public (e.g., with a group of individuals), rather than in a private context (e.g., when an individual is alone), and both emotions can be elicited after a nonmoral or moral transgression (Tangney & Dearing, 2002). A third, and more cognitively based, distinction between shame and guilt is based on a class of theories known as *appraisal theory*. In Lazarus's (1991) model, he distinguished between shame and guilt using a flow-chart of cognitions that lead to each emotion. Guilt is elicited when a moral transgression has occurred, whereas shame is elicited when the individual fails to live up to an ego-ideal. Clearly, this distinction between

shame and guilt overlaps with the nonmoral/moral distinction. A fourth, related, cognitive approach referred to as *attribution theory* claims that shame arises when an undesired outcome is perceived to reflect internal, stable, and uncontrollable causes (e.g., test failure due to low ability), whereas guilt is experienced when the same outcome can be explained in terms of internal, unstable, controllable characteristics, such as low effort leading to test failure (Tracy & Robins, 2004; Weiner, 1985).

Different from the more cognitively oriented approaches, a fifth approach

differentiates the two emotions from a functionalist perspective (Barrett, 1995), in which the functions that shame and guilt serve are used to distinguish between the two emotions. From this perspective, shame motivates a withdrawal or avoidance response to essentially hide the self, communicates submission, and highlights important standards from which the individual has deviated. On the other hand, guilt motivates approach tendencies, in which the guilty person is inclined to apologize, communicates an awareness of proper behavior, and highlights important standards (Barrett, 1995; Frijda, 1986). A sixth perspective considers shame as an innate, basic emotion, whereas guilt is not considered an emotion at all. Instead, guilt is considered a sociolegal condition of being responsible for a transgression (Ortony, 1987), with the recognition that this condition may be associated with a variety of emotions (e.g., sadness, shame).

Finally, Lewis's (1971) conceptualization of shame and guilt represents a seventh distinction between the two states. In her view,

"The experience of shame is directly about the *self*, which is the focus of evaluation. In guilt, the self is not the central object of negative evaluation, but rather the *thing* done or undone is the focus. In guilt, the self is negatively evaluated in connection with something but is not itself the focus of the experience." (p. 30; emphasis in original)

Shame is considered a focus on the entire self by the self, or a real or imagined other, (Lewis's phrases, "How could *I* do that?"), while guilt focuses on the behavior or act of the person ("How could I do *that*?"). Because of this distinction, the phenomenological experience of the two emotions is quite different. Lewis (1971) described the experience of shame as very painful, involving a sense of worthlessness, and an urge to escape or disappear. In contrast, guilt is a less painful experience, because the focus is instead placed upon the act, and people feel anxiety, tension, or an urge to repair the wrong done.

This distinction is the most well known of many distinctions Lewis attested to when discussing shame and guilt, but importantly, Lewis saw the two states as resulting at least from different *aspects* or appraisals of the "same" event (and its after-effects). She did not view shame to be a greater emotional source of psychological problems than guilt. Instead, she viewed both emotions as a source of personal growth, with adaptive/maladaptive outcomes depending on a variety of other factors (e.g., repressive versus sensitizing styles of defense). Finally, Lewis stated that the two states occur in a cyclical fashion

with each individual experiencing both emotions in rapid succession (Lewis, 1971).

1.3.2. Difference between Shame and Guilt

Recent theory and research, has identified important differences between these two closely related emotions. These are the differences that appear to have rather profound implications both for psychological adjustment and for social behaviour (Tangney & Dearing, 2002).

According to Lewis (1971), a key difference between shame and guilt focuses on the role of self in the experiences of oneself. She described shame as directly about the *self* which is the focus of evaluation. On the other hand, she described guilt as the *thing* that has been done or undone is the focus of evaluation. Therefore, shame is an acutely painful emotion accompanied by a sense of being small, powerless and worthlessness which does not need an audience to witness because it is about the self only. The emotion of shame often leads to a desire to escape or to hide. On the other hand, guilt is seen as a less painful experience than shame because in guilt, the primary concern of the individual is the behaviour that has been done or undone so it does not affect one's core identity or self-concept. Guilt may include a sense of tension, remorse and regret over the behaviour but it is not about the self (Tangney & Dearing, 2002).

Lewis (1971) proposed that this differential emphasis on self ("*I* did that horrible thing") versus behaviour ("I did that horrible *thing*") leads to very different phenomenological experiences. She described shame as a very acutely

painful emotion that is typically accompanied by a sense of shrinking or of "being small" and by a sense of worthlessness and powerlessness. Shamed people also feel exposed. Although shame does not necessarily involve an actual observing audience that is present to witness one's mistakes, there is often the imagery of how one's defective self would appear to others. Lewis(1971) described a split in self-functioning in which the self is both agent and object of observation and disapproval. Shame often leads to a desire to escape or to hide just like sinking into the floor and disappear.

On the other hand, Lewis (1971) viewed guilt as typically a less painful and devastating experience than shame because, in guilt, our primary concern is with a particular behaviour, somewhat apart from the self. Feelings of guilt can be painful nonetheless. Guilt involves a sense of tension, remorse, and regret over the "bad thing" done.

Table 3: Key dimensions on which shame and guilt differ

	Shame	Guilt
Focus of evaluation	Global self: "*I* did that horrible thing"	Specific behaviour: "I *did* that horrible thing"
Degree of distress	Generally more painful than guilt	Generally less painful than shame
Phenomenological experience	Shrinking, feeling small, feeling worthless, powerless	Tension, remorse, regret
Operation of "self"	Self "split" into observing and observed	Unified self intact

	"selves"	
Impact on "self"	Self impaired by global devaluation	Self unimpaired by global devaluation
Concern of the "other"	Concern with others' evaluation of self	Concern with one's effect on others
Counterfactual processes	Mentally undoing some aspect of self	Mentally undoing some aspect behaviour
Motivational features	Desire to hide, escape, or strike back	Desire to confess, apologize, or repair

Table 4: Key Similarities Between Shame and guilt

Both fall into the class of "moral" emotions
Both are "self-conscious" emotions
Both are negatively balanced emotions
Both involve internal attributions of one sort or another
Both are typically experienced in interpersonal contexts
The negative events that give rise to shame and guilt are highly similar (frequently involving moral failures or transgressions).

1.4. Shame and Guilt and Psychopathology

Shame and guilt are detected as problematic concepts at the individual level even though they are assumed to have adaptive functions at the community level. Pride is supposed to be a positive self-conscious emotion (Lewis, 1993). However, some theorists mention that the type (alpha pride) or the intensity (hubris) of this emotion may be related to psychopathology (Lewis, 1992; Tangney and Dearing, 2002). As a result, self-conscious emotions have been examined as having features contributing to various types of psychopathology which range from emotional disorders to personality disorders (Bradshaw, 1988; Fossum and Mason, 1986; Kohut, 1971; Rodin, Silberstein and Striegel-Moore, 1985; Tangney, Wagner and Gramzow, 1992).

Previously, a lot of concentration has been focused on the role of guilt in psychopathology (Pineless, Street & Koenen, 2006). Guilt is assumed to stem from unacceptable impulses and allows a range of self-primitive processes that result in symptoms of psychopathology. Tangney et al. (1992) mention that Freud more focuses on the guilt, particularly on its connection with obsessional neuroses, masochism, and depression. Freud (1915) refers shame as a reaction formation against sexually exhibitionistic impulses. However, the role of shame in psychopathology has been better comprehended with the emergence of self psychology. H. B. Lewis (1971) mentions that shame sets up conditions in which the boundaries of self become permeable.

Some theorists have suggested that Freud's failure to distinguish between the ego and the self lead to misinterpretations of his parents' guilt and shame experiences (Lewis, 1987; Nathanson, 1987). Lewis (1971) underlies the differential roles of shame and guilt in psychopathology. Moreover H. B. Lewis (1971, 1987) assumes that the proneness to shame and guilt lead to development of specific psychopathological symptoms. This view may point out while shame feeds the tendency to develop an emotional disturbance; guilt leads to tendency to develop thought related disorders.

Shame has been assumed to be a vulnerability factor for the case of depression (Tangney, Wagner and Gramzow, 1992). Several researchers have found that even in non-clinical samples, depression is associated with both state shame (Ferguson, Stegge, Miller & Olsen, 1999) and trait shame (Andrews, Qian and Valentine, 2002). However, regardless of the empirical findings that point out shame as a characteristic of depression, it is remarkable to see that Diagnostic and Statistical Manual IV-TR (DSM-IV-TR; American Psychiatric Association, 2000) classifies guilt, rather than shame, as a symptom of a Major Depressive Episode. In fact, guilt has been found to be associated with depressive disorder by some researchers empirically (Baumeister, Stillwell & Heatherton, 1994; Ferguson et. al., 1999). Still Tangney (1991) suggests that a reasonable amount of guilt is functional rather than being maladaptive. On the other hand, some other researchers insist that guilt has dysfunctional aspects in addition to its relationship with depression (Gilbert & Miles, 2000).

In fact, shame and guilt may have functional and dysfunctional aspects and both have common and specific characteristics which are related to psychopathology. Although many researchers have tried to differentiate these two emotions in order to obtain their unique characteristics related to psychopathology; it is useful to differentiate the types of shame or guilt in itself in order to determine functional and dysfunctional characteristics. A lot of definition has been made for both shame and guilt and classifications has been made by physiological, behavioural and cognitive components in terms of their intensity, functionality or motivation.

To define shame, Fowler (1995) has placed shame experiences on a continuum. At one end, there is healthy shame which serves as protective factor for the harmony of society and for the personal worthiness. In the middle, there is perfectionist shame that is internalized based on social discrimination. At the other end, there is toxic shame which is the result of persistent abuse or objectification. The extreme point is the shamelessness which is related to narcissism and sociopathy. Interestingly, for Broucek (1991), individual manifestations of shamelessness are a defence against shame.

Harder (1995) attempts to define guilt by making the distinction between chronic psychopathological guilt and mild transitory guilt which is common in many people's lives. Similarly, according to Tangney et al. (1992), there exist two types of guilt: Ruminative (anxious) guilt and Non-ruminative (empathic) guilt (Tangney et. al., 1992). The first one refers to pathological guilt and the latter to empathic guilt and it is experienced by everyone.

Several studies (Tangney et.al., 1992; Keltner and Buswell, 1996) have found empirical support for the distinctions between shame and guilt in terms of their unique characteristics in relation to psychopathology. Drawing on Lewis' notion that certain individuals are prone to shame while others are more prone to guilt. Tangney and her colleagues (1992) find significant correlations between shame-proneness and general psychosocial maladjustment. In addition some specific dimensions of psychopathology such as somatisation, obsessive-compulsive traits, paranoid and idiosyncratic ideational styles, proneness to hostility and anger, interpersonal sensivity, both trait and stait anxiety, and depression are also found to be related to shame-proneness. However, guilt-proneness is generally demonstrated as moral rather than pathological. Therefore, it is found to be inversely related to hostility and danger, phobic anxiety and depression.

Some explanations have been made to attempt to solve the conflicting results in mental health issues about the dysfunctional aspects of guilt. For example as Tangney (1996) argues, guilt is related to psychopathology only when it is fused with shame or when it reflects general negative affect. In the same way, Eisenck and Wilson (2000) define guilt as a component of neuroticism which is considered to be a general negative affect. In fact shame is also a negative affect, but the focus of the negative affect defers in two emotions, leading to distinct phenomenological experiences. Another explanation may be the fact that guilt is always measured in a mild, emphatic form. Hence, it is not related with psychopathology of Tangney as she

consistently emphasises “shame-free guilt” as a favourable human emotion experience.

Initial methods of “measuring” guilt maybe another explanation for controversial findings of existence of pathological aspect of guilt. There is little direct empirical verification that supports theoretical discussion on the issue. The lack of empirical research may stem from the difficulties in the discrimination in measurement of shame and guilt. Especially, the first guilt scales (e.g., Bass and Durkee, 1957; Mosher, 1966) were always criticised about the low discrimination reliability between shame and guilt (Tangney, 1966). Consequently, although shame maybe assumed to have stronger associations with psychopathology then guilt does, researchers should not stop searching the potential important role of guilt. There has been very limited study on the specific relationship between “shame-free guilt” and psychopathology. For example, in their study Kubany and colleagues find that combat-related guilt appears to be positively related to post-traumatic stress disorder severity, which may contribute to the maintenance of other trauma-related psychopathology (Kubany et. al., 1996).

While in the majority of studies, guilt-proneness which is independent of shame-proneness has been demonstrated to have no relationship or to have a negative relationship with psychopathological symptoms, shame-proneness (which is independent of guilt-proneness) has been linked to symptoms of anxiety, depression, proneness to narcissistic and borderline personality disorders, and posttraumatic stress (e.g. Tangney et. al., 1992). As it is a psychological stressor, shame may have implications on physical health. In

addition, research on the consequences of sexual abuse provides further support for the contributing effect of shame (Feiring, Taska and Lewis, 1996; 1998; Feiring, Taska and Chan, 2002). Similarly in social anxiety fear of negative evaluation is considered to be the result of feelings of shame (Gilbert, 2000). According to Sanftner & Crowther (1998), while shame proneness is associated with eating disorder symptomatology, guilt proneness is not. However considering the difficulty women with eating disorders has in confused emotional states (Johnson &Connors, 1987) measurement of two such closely related emotions may be particularly challenging.

As another self-conscious emotion, pride has a lot of definitions that have been made in terms of its intensity, functionality, or motivation. For instance, Lewis (1991) describes excessive amount of pride as hubris which is a consequence of the evaluation of success in regards to one's standards and rules. Hubris is highly positive and emotionally rewarding because individual feels good about himself. However, it is difficult to sustain since no specific action precipitates it. Lewis refers to hubris as "addictive" (Lewis and Havilant-Jones, 2000). Because of the "addictive" nature of this positive self-attribution, those prone to hubris derive little satisfaction from the feeling.

Many theorists (Broucek, 1991; Morrison, 1989; Lewis, 1992) argue that the relationship between shame and pride is related to psychopathology. For example, in ability to cope with shame and humiliation underlies pathological narcissism in which the dominant emotion is pride (Kempbell, Foster & Brunell, 2004). Lewis's (1971) notion of shame-proneness, as elaborated by Tangney (1992) is helpful in thinking about narcissism and shame. Because of this focus,

failure is likely to produce shame, and success is likely to result in hubris. The tendency to make global evaluations affects both these standards and the evaluative process of failure in regards to these standards. A person can avoid shame by never experiencing failure; she can avoid failure by setting her standards low so as never to risk the possibility of failure to meet them. Low standards, because they are easily met, create a feeling of hubris. People who are prone to making global attributions also set unrealistically high standards, which are difficult if not impossible to meet, and thus create more shame for them.

Since most of the related studies' findings are correlational in nature, casual relationships between self-conscious emotions and psychopathological symptoms cannot be uncovered. Nonetheless, it is becoming clear that psychopathological symptoms cannot be understood without taking into account the self-conscious emotions involved (Zahn-Waxler, 2000). Consequently, most important influence of self-conscious emotions may be seen on the areas of assessment and classification of certain psychological disorders and psychotherapeutic alliance in clinical settings. By using this knowledge, clinicians can diagnose more accurately the antecedents of disorders. Furthermore, the findings of every new study on this issue would encourage preventive studies by illuminating the relationship between self-conscious and psychopathology.

Since self-conscious emotions have a very important role in psychopathology, adolescents who experience shame and guilt through and later on their mothers' illness process are likely to develop psychopathology later in their lives. Although many research were made to distinguish shame and guilt or

to find the relationship between self-conscious emotions and psychopathology, literature is missing of research that are trying to discover what kind of maladaptive behaviours has been waiting for adolescents with maternal cancer. No research has been done to understand the emotions of shame and guilt these adolescents feel and how they will be affected unless understood and treated properly.

An adolescent with maternal cancer has been surrounded by difficulties in school, in the family, since the roles are changing because of the mother's illness, and while dealing with the mood of his or her parents. To cope with these difficulties he or she must have strong coping mechanisms and core emotions such as pride to help him/her to survive. But on the other hand, self-conscious emotions such as shame and guilt are an obstacle standing on his/her way of coping. Furthermore, these emotions are not as on the surface as other emotions such as anger, sadness and fear. So they are more difficult to spot and distinguish and finally understand. This study has been trying to evoke these self-conscious emotions and let adolescents talk about them. This study has also been trying to distinguish between shame and guilt to find a way to enlighten the clinicians for the forthcoming danger of psychopathology.

Since guilt and shame are emotions which are not easy to carry on the surface of consciousness, a film was used as an evoking process. Although it was used only one time for each participant, the affects of cinematherapy has been used by clinicians for an adequate time.

1.5. Cinematherapy

Cinema is an entertainment and art industry which allows people to relax and enjoy themselves. However, recently movies have been started to use as a way of dealing with a variety of problems. It is seen that cinema is being used as a reference to significant problems or situations in psychotherapy. Berg-Cross, Jennings, and Baruch (1990) defined cinematherapy as "a therapeutic technique that involves having the therapist select commercial films for the client to view alone or with specified others as a means for therapeutic gain" (p.135) On the other hand Dermer and Hutchings (2000) defined cinematherapy as "the use of film as an intervention" (p. 163). Furthermore Tyson, Foster, and Jones (2000) defined it as "a therapeutic intervention allowing clients to visually assess a film's characters' interaction with others, the environment, and personal issues, thereby developing a bridge from which positive therapeutic movement may be accomplished" (p. 35). And similarly, Sharp et al., (2002) described cinematherapy as "a therapeutic technique that involves careful selection and assignment of movies for clients to watch with follow-up processing of their experiences during therapy sessions" (p. 270). The use of movies in psychotherapy appears as a therapeutic intervention in psychotherapy, rather than a special kind of therapy (Hesley & Hesley, 2001). Within this framework, movies are being utilized for educating and challenging clients, normalizing and reframing problems, and expanding ideas (Dermer & Hutchings, 2000).

1.6. Aims of the Study

In general, the current study was designed in accordance to five major goals. The first goal was to discover if the adolescents with the maternal cancer feel shame and/or guilt. Since self-conscious emotions are based on social concern; they are not automatized like basic emotions like anger, sadness or fear (Johnson-Laird & Oatley, 1989). Furthermore, they are a lot more complex and not on the surface so it was anticipated that these adolescents may have been feeling shame and guilt.

The second aim of the study was to discover if emotions of shame and guilt differ from each other. Many theorists have been working on distinguishing between shame and guilt. Since shame is about the "self", whereas guilt is about the "thing" done or not done (Lewis, 1971), it was assumed that these adolescents might be feeling shame because they blame themselves for being the reason of the illness or/and not being helpful or/and protective enough.

The third aim of the study was to reveal if watching movie with these adolescents help evoking the emotions of shame and guilt and if they idealize themselves with the character what so ever. Dermer and Hutchings (2000) defined cinematherapy as the use of film as an intervention so another aim was to prepare these adolescents for an upcoming intervention process so their emotions of shame and guilt will be on the surface and they will be ready to share them with the researcher.

The fourth aim was to discover if the emotions of shame and guilt can be normalized in the intervention stage of the study and if they can be replaced by another self-conscious emotion, which is pride.

The fifth aim of the study was to propose a precaution model for the clinicians since unresolved shame and guilt may cause psychopathology in these adolescents.

More specifically, the current study aims to answer these questions:

1) To what extend adolescents with maternal cancer experience guilt, shame and pride.

2) Is it possible to distinguish the emotions of guilt and shame these adolescents experience?

3) Is cinematherapy efficient in evoking and revealing the emotions of shame and guilt these adolescents experience?

4) Is it possible to normalize the emotions of shame and guilt these adolescents experience and replace them with pride?

5) What precautions can be taken in order to prevent these adolescents to develop psychopathology?

CHAPTER

METHOD

2.1. Participants

The current study is a study based on sample of 10 adolescent participants whose mothers had breast cancer. The inclusion criteria for the research were adolescents' mothers to be ill for at least 5 years and to be alive. The adolescents were referred from Ankara Ahmet Andiçen Hastanesi Onkoloji Servisi and Samatya Eğitim ve Araştırma Hastanesi since their mothers have been receiving chemotherapy in these hospitals. 4out of 10 participants were females and 6 of them were males. Their age varied from 16 to 20. 4 sessions were conducted with each participant. Since each participant was at a younger age when their mother had cancer, it is important to evaluate their state of emotion according to their illness process ages (See table 5).

Table 5: Participants' age comparison.

	Age, now	Age , then	Education, now	Education, then
Gamze	20	16	University	High-school
Hülya	20	16	University	High-school
Cansu	17	14	High-school	Elementary School
Zeynep	16	14	High-school	Elementary School
Onur	20	15	University	High-school
Ömer	19	14	High-school	Elementary School
Ömer Faruk	18	14	High-school	Elementary School
Önder	17	13	High-school	Elementary School
Fırat	17	13	High-school	Elementary School
Ahmet	15	13	High-school	Elementary School

2.2. Instruments

2.2.1. Demographic Form

A form prepared for collecting adolescent's information of age, gender, parents, educational level and socioeconomic status. Most importantly their knowledge of mothers' illness was evaluated.

2.2.2. Sentence Completion Test

Two different types of sentence completion tests were developed by the researcher based on capturing the emotions of shame and guilt. First test was formed of nine sentences in which every sentence has a blank. Each of the blanks was supposed to be filled by an emotion such as shame, guilt, fear, sadness and anger. The test has two sentences which were designed to reveal guilt, two sentences for capturing shame, two sentences to bring out sadness, two sentences to show the emotion of fear and finally one sentence to reveal anger (see table 6). Participants were informed to fill these blanks with the first emotion word popped up in their minds. The first test was given to the participants in the first session.

The second type of test was also made of nine sentences but with the addition of six more sentences which were about the film “Pandora’s Box”. The participants were, again informed to fill the blanks with the first emotion word they felt. The second type test was given to the participants in each session starting from the second one.

Table 6: Distribution of Sentence Completion Test's sentences according to the emotions they reveal.

	Sentence 1	Sentence 2
Shame	My mother got sick because I..... .	I believe that cancer happens because of..... .
Guilt	If I..... my mother wouldn't get sick.	If she was ill now, I ..... .
Fear	When she had an operation for her breast I felt.....	If she didn't get sick I would feel.....
Sadness	When my mother first got sick, I felt.....	When she started to lose her hair, I felt.....
Anger	I feel ..... about her because she got sick.	

2.2.3. The Film "Pandora's Box"

A Turkish film directed by Yeşim Ustaoğlu in 2007. The story is about the lives of three generations in a family from Black Sea originally but the children had migrated to İstanbul leaving their mother in Black Sea: A grandmother, two daughters, a son and a grandson. All of them have their own problems and also have been having undefined and unresolved problems within. But they all come together because of the illness of their mother (Alzheimer). The lives of three children are change greatly because the mother comes to live with them in İstanbul. But they have difficulties to take care of her.

The eldest sister approaches her mother as a problem to solve, tries to control her every move, the middle sister does not want to take care of her mother because believes that her mother did not love her because of something she did wrong, and the youngest brother (disgrace of the family) does not even try to help her. The grandson, who had never met his grandmother before, becomes very fond of her, understands her and a great affection arises between them, so much that they flee to Black Sea where they live together in grandmother's house until the moment the grandson lets his grandmother to go to her "mountain" because she wishes so. This film was chosen because the relationship between the three children and their mother may be helpful to surface the emotions of guilt and shame the adolescents experience through their mothers' illness. Also the relationship between the grandson and the grandmother might also reveal different emotions.

2.3. Procedure

2.3.1. Pre-study

On five adolescents aged 12-18, TAT cards were applied in Ankara Oncology Hospital in June, 2009. According to the interpretation; it was found that these children mainly had guilt and shame emotions about the time their mother had cancer or at the present time. Other dominant emotions were sorrow, fear of separation or death and regret. According to the pre-study, working on shame and guilt were decided.

2.3.2. Session One

The first session was formed as the introduction session. Each participant and their mother or father was given the consent and the demographic form after the concept of the study was explained and the adolescent was interviewed privately. He or she was questioned if he/she is aware of the mother's illness, about his/her mother's current health situation and if he/she wanted to participate in this study. Then, each participant was given the Sentence Completion Test. After completing the test, they were given appointment for the second session in which researcher and the adolescent will watch the film.

2.3.3. Session Two

Approximately three days after the first session, the film was watched with each participant privately and the second type Sentence Completion Test was given. Then, each participant was given appointment for the third session.

2.3.4. Session Three

In the third session, each participant was interviewed privately for approximately 20 minutes. These interviews were designed as interventions and aimed to let the adolescent tell all the process starting with the day he/she learned that his/her mother has cancer. Throughout the intervention, participant was directed with questions such as "What did you feel when you first learned that your mother was ill" or "How about the roles in the family? Did they change?" With these kinds of questions, the frame of the intervention was set but inside this frame, the adolescent was left free in order to capture the emotions of shame and guilt.

At the end of the intervention, a speech was given by the researcher. The speech aimed to normalize the emotions of shame and guilt and tried to replace them with pride. Such as, "I think what you did to help your mother is something you should be proud of" or "I believe that your mother is very proud of having a son/daughter like you".

The Sentence Completion Test was given for the third time to the participant after the intervention was over and he/she was given the appointment for the fourth and final session.

2.3.5. Session Four

Approximately one week after the third session, each participant was given the Sentence Completion Test for the last time. It was aimed to understand if the effect of the film and interview lasted. Furthermore, each participant was asked if he/she needed professional help to resolve his/her feeling about the situation and for the ones who did, a psycho oncologist in Ankara and İstanbul

was recommended.. Unfortunately the number of participants who returned for the fourth session was 3 out of 10 so it was determined to leave the fourth session out of the analysis.

CHAPTER 3

RESULTS

3.1. Results according to "Sentence Completion Test"

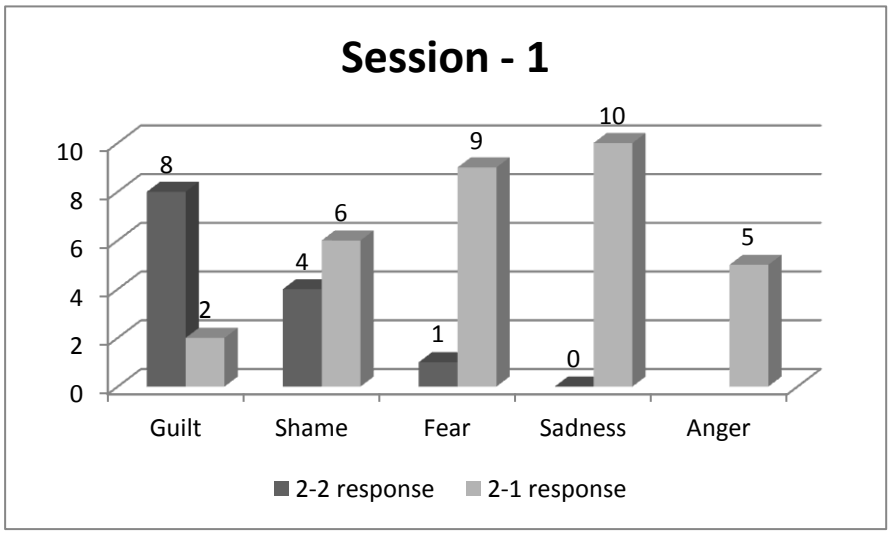
In the current study, it was aimed to reveal if the emotions of shame and guilt differentiated from each other throughout the four session process by the involvement of "intervention" and the "film". Although the sudy was planned for four sessions, as mentioned above, the fourth session was left out of the analysis.

The "Sentence Completion Test", revealed 5 main emotions throughout the sessions which are "shame", "guilt", "fear", "anger", and "sadness". The analysis were made according to the frequency of these emotions the 10 participants revealed in three sessions. As mentioned before the survey was designed in a way that each emotion, except for anger, have two sentences to reveal themselves. Only "anger" has one sentence to be captured.

3.1.1. Results of Session One

Session one, being the meeting session, was the first time the participants came across the sentences. In this analysis, the frequency of the emotions revealed by the 'Sentence Completion Test' is exibited (see graph 1). Each participant had two sentences to reveal shame, guilt, fear and sadness and one sentence to reveal anger.

Graph 1: Frequency of the emotions guilt, shame, fear, sadness and anger.

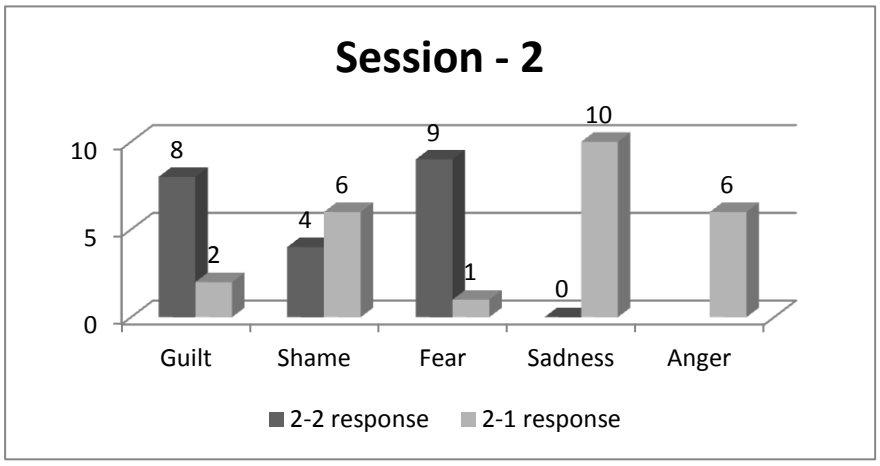


According to the results, 8 participants revealed emotions of guilt in two of the expected sentences and 2 participants revealed guilt in only one sentence. On the other hand only 4 participants uncovered shame in two sentences, while 6 of them showed shame only in one sentence.

3.1.2. Results of Session Two

In session two, the film "Pandora's Box" was watched with the participants privately, then, the second version of Sentence Completion Test was given with the initial sentences about the film. The frequency analysis was made according to the number of emotions each participant revealed (see graph 2).

Graph 2: Frequency of the emotions guilt, shame, fear, sadness and anger.

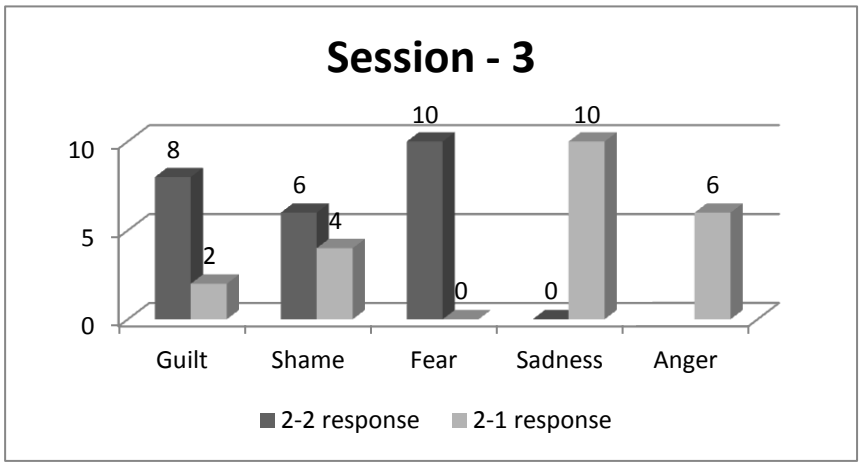


In the study, it was predicted that the film "Pandora's Box" would help the frequency of emotions of shame and guilt to increase but according to the results, the frequency of anger and fear were increased. So the results yielded that although Pandora's Box did not make any significant effect on evoking the emotions of shame and guilt but it had an effect on the emotions of fear and anger.

3.1.3. Results of Session Three

In the third session, 20 minute long interviews were conducted with the participants. Then, Sentence Completion Test was given. Again, the frequency analysis of the emotions the participants revealed was examined (see graph 3).

Graph 3: Frequency of the emotions guilt, shame, fear, sadness and anger.



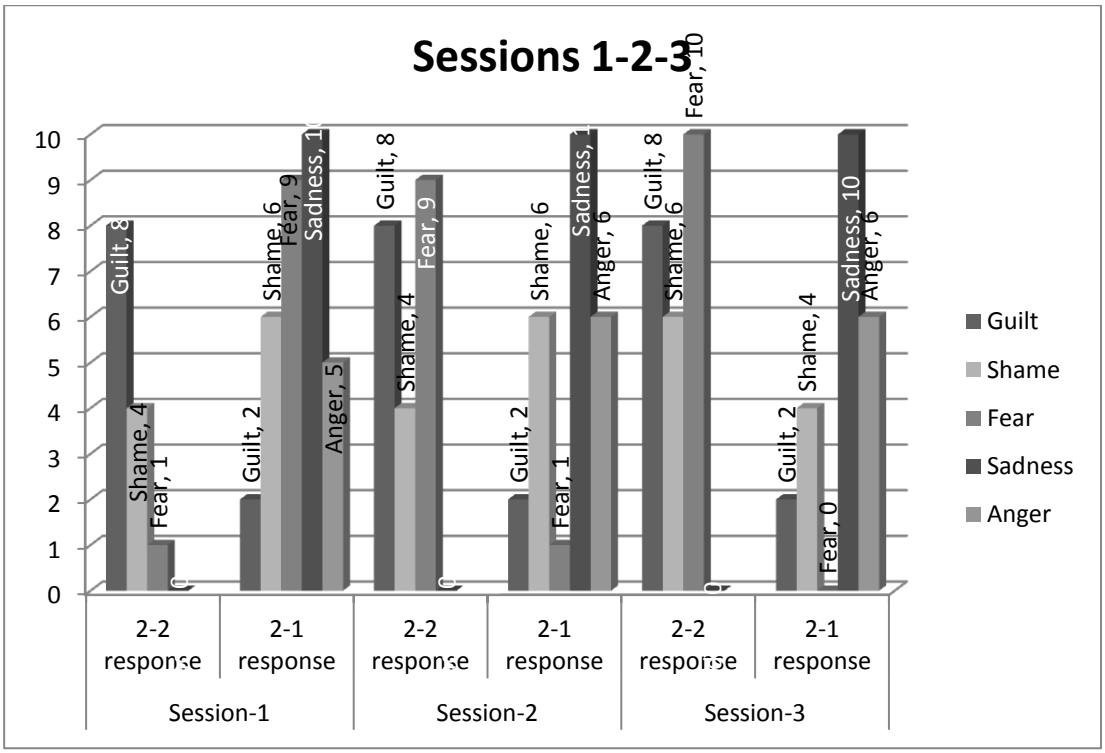
Interventions aimed to decrease the frequency of shame and guilt and replace them with pride if possible. According to the results the interventions did not make any significant effect on the participants.

3.1.4. General Results of Sessions 1-2-3

In the current study, it was aimed to capture the emotions of shame and guilt with the Sentence Completion Test and to understand if these emotions decrease and/or increase by the interference of external effects such as the film and interventions. It was aimed to analyse the frequency of these stated emotions and see if they changed from session to session. According to the general results of three sessions, the Sentence Completion Test was successful in collecting and capturing the emotions of anger, sadness and fear and above all, it was successful in revealing the emotions of shame and guilt and differentiate them from each other. Nevertheless, the results yielded that neither

interventions nor “Pandora’s Box” made any significant impact on participants’ prominent emotions (see Graph 4).

Graph 4: General Results for Sessions 1-2-3.



3.2. Results according to the Intervention Analysis

The current analysis was designed as the content analysis and 5 topics which were common in 10 interviews were set.

3.2.1. Learning about Mother's Cancer

Under this title, the adolescents were asked how and when they had learned that their mothers have cancer. It is to be examined in two different subtitles. 1) When and how the adolescents learned that their mothers have cancer and who told them. 2) How did that news affected them.

7 adolescents out of 10 who participated in the survey stated that they did not know that their mothers had cancer but they either learned during the breast surgery or after the surgery. 5 of the adolescents were told about their mothers' cancer by the doctor or by another relative (father, brother, uncle etc.). Adolescents who were told by their mothers reacted in different ways. "I wanted to get out of hospital and forget about that she had cancer so I started walking" stated 17 year old male adolescent. Likewise a 16 year old felt "as if I was going to lose her so I said I was sorry and left my family and got out of the room". Another 16 year old female adolescent reacted differently and she "hugged my mum and we both started crying. She just got out of the surgery and she was apologizing to me and my brother that she did not tell us before. I didn't care, I was too scared then." Adolescents who were told by another relative were more confused and their primary focus point was not the cancer but "where is mum? Why isn't she telling me? Is she dead?" stated a 20 year old female. 5 adolescents who weren't told by their mother about the illness expressed that they thought their mothers were going to die. "I wasn't with her in the hospital

through the surgery because I didn't know that she was having one! When my father told me I was almost convinced that she was dead" stated 16 year old male. "I hugged my father and asked him to tell me the truth..Is she going to die?"

Questions about how, when and from who revealed that adolescents who were told by their mothers and before the surgery accepted the illness relatively easier than the others. When asked why; 20 year old female expressed that "she was standing right in front of me and she was ok even though she had cancer. So I thought we can handle it together". In adolescents who were told by a relative and after the surgery the focus was not on the cancer but on "how is mum, is she dead?" as a 15 year old male told.

Lastly adolescents were asked about their feelings when encountered with this kind of information. An 18 year old male stated "When my father told me that she had cancer I felt fear..Fear that I might lose her". For 16 year old the moment was "crystal clear". "I felt angry because I was the last person to know. I still feel angry with her because we share everything". A 17 year old male who was told by his mother expressed "I felt sad and desperate. I didn't know how to react". A 17 year old female who was told by her brother felt "as if I had lost her already. I didn't know what to do. It was the saddest moment in my life".

The private interviews revealed that how the adolescents learned about their mothers' illness affected the whole process that they went through with their mothers. The prominent emotions these adolescents experienced at the very moment they found out their mothers' illness, were "sadness", "fear of loss", "anger" and "desperation".

3.2.2. Not being able to communicate with the mother about her cancer

Under this title, the relationship between the mother and the adolescents was examined. Again 2 subtitles were determined. 1) Adolescents who desired to communicate in the family about the cancer but were obstructed. 2) Adolescents who were reluctant about communication in the family.

4 female adolescents were willing to communicate with their mothers about their illness. “I thought that if we speak about her illness it would be more normal.. So I tried but she was both very tired and reluctant” stated 20 year old female. “I think, now I realised that the reason she never spoke about her cancer was to prevent us, but then, I thought she thinks that won’t understand her and it made me angry” said the other 20 year old female. They were not only blocked by their mothers but also by their fathers and the other family members (grandmothers, uncles etc.). “One day, after she came back from the chemo, I wanted to understand so I asked about chemo but my father stopped me and send me to my room, ‘she is too tired to speak about it’ he said” This 17 year old female felt sad and frustrated “ So I never asked again” she stated. “I sensed that my mother won’t speak to me about her illness because I was very young and wouldn’t understand her so I think she tried to prevent me from being sad about it. But it made me feel more frightened because I didn’t know what was happening. I wish we communicated more” stated the 16 year old female.

6 male adolescents were very reluctant to communicate about cancer with their mothers. “I didn’t want to speak to her about the cancer because I was

afraid that it would make her upset" stated 15 year old male. "I, sometimes, thought that the more we pretend as if cancer never happened the more it will go away..So I never spoke about it" said the 17 year old male. Even though their mothers was willing to communicate some of the adolescents felt "if I speak to her about the illness I would make her and myself sad". 6 male adolescents' statements were in a consensus of fear of making their mother upset and speaking about the illness will "make it more real". The general tendency was to pretend the cancer never got into their family.

The adolescents whether they communicated with their mothers or not, were in ambivalence state of emotion. Females preferred communication but still felt fear about making their mothers upset so they never were decisive about communication. Furthermore they were blocked not only by their mothers but also by their fathers which caused frustration with loneliness and isolation, hence they felt the fear of not knowing. On the other hand, males who preferred not to communicate still felt the fear of not knowing because they somehow believed that pretending the cancer never happened will correct their mothers' situation. The prominent emotions these adolescents experienced throughout the process of healing were "fear of not knowing", "sadness", "and anger" and "fear of making the mother upset".

3.2.3. Managing House Hold /Change of House Roles

Under this title, how the house roles changed after the mother had cancer was studied. Two subtitles were stated. 1) What kind of change occured in the roles of adlescents within the family. 2) How did these changes effected them outside the family, in social life (in school, with friends etc.).

In a traditional Turkish family, the house roles were stated as mother the care giver who is in charge of cooking, cleaning and order. On the other hand the children function as the least responsible individuals. Their most important task is to go to school and be good at it. 10 out of 10 adolescents stated that the roles in the house was completely changed. “Mum was too sick to even stand up, my grandmother was at home functioning as my mother and I was doing my best to help her” said 17 year old male. “As being the only female in the family other than my mother, all the house work was on me. I cooked and cleaned” said a 20 year old female. Since they were all students at the time they were working both at home and in school. “When I got home from school I was usually hungry bu my mum was too tired to cook for me so I learned how to cook myself” stated 17 year old male. “I sometimes thought as she (mum) as my child and myself as her mum” told the 17 year old female.

When the effects of these changes on their social life was questioned all of the adolescents agreed that their life was not that social anymore. “I used to go to the movies with my friend every Friday but when my mum got sick I thought that I should stay at home and be with her” explained 18 year old male. “I felt bad and unfaithful for every moment I spent outside home and when I’m not at school” stated 20 year old female. On the other hand couple of

adolescents felt anger. “I remember when my freinds phone me and say let’s meet, I felt angry with her because I wanted to go out but she was sick. Then I felt bad about myself for being angry at her” expressed a 18 year old male. Females usually agreed that they felt tired for the most of the time. “I was at high-school then and it was a hard school year. I had to work hard but all the house work was on me because mum was ill. So I learned how to plan my day which is a great gain for me” stated 20 year old female. On the other hand another 20 year old female stated “I was to tired and felt like couldn’t manage school and house together so I asked for my aunt’s help who ocassionally stayed with mum. This made me feel inadequate”. Likely 16 year old female felt “like I was doing all I can but it wasn’t enough. I barely saw my friends outside the school during this time”. All the adolescents expressed guilt in their statements. “I as trying hard at home and at school but mum’s condition was getting worse so I was feeling guilty because I wasn’t helpful enough” stated 17 year old female. Furthermore both male and female adolescents agreed that “all the time I was trying to help mum I was getting angry at her. Maybe not at her at her cancer because I wanted to go out and have fun but I had to help cleaning instead”. Nevertheless adolescents stated “pride” during the interview. “Now I understand how much effort I made so I’m proud of myself in many ways” says 18 year old male. The prominent emotions these adolescents experienced throughout the process were “anger”, “guilt” and “pride”.

3.2.4. Feeling Guilt

Under this title, the feelings of guilt and in under which circumstances the adolescent experienced, was examined. Two subtitles were revealed. 1) Feeling guilty through the process of cancer. 2) Feeling guilty at the present time while evaluating the process of illness.

All 10 adolecents revealed emotion of guilt in the interviews. They either felt guilty about not being able to protect their mothers from cancer or could not help enough through the sickness.

A 20 year old male stated “I felt and still feel guilty because I couldn’t save her. I knew she was very upset at the time because of some conflicts in the family and I was aware that she was upset so I could find some help for her I guess”. Or 17 year old female expressed guilt as “I knew their (father and mother) relationship was never a peaceful one they argued a lot and this made mum upset. I guess I had to do something to stop them from hurting each other.” Another 17 year old male stated his guilt by “My father was dead when I was little and my uncles and my mother never got along well. So they always did something to make her sad. I always thought that if I was a little older so that I could protect her”.

18 year old male stated his guilt as “I wish I was older (he was 14) so I could help her more” Or 20 year old female expressed her guilt as “I should have stayed home with her and help her more. It was just so hard for me to handle I wish I was stronger.”

All of the adolescents are aware that in the time their mother had cancer, they were too young to handle the whole situation by themselves. Nevertheless

results indicate that understanding the fact that they were too young at the time does not prevent them from feeling guilty. 10 out of 10 adolescents admit that they still feel guilty. For example 18 year old male expresses his guilt as “I still don’t talk to my mum about her cancer even though I feel guilty about it. I guess I am still afraid that one day she might get sick again”. Or 20 year old female thinks that “It is my fault that mum got better sooner because I couldn’t do my best to help her. I could have helped dad more.”

Since all adolescents express guilt, the most prominent emotion these adolescents experienced is “guilt. On the other hand, even though adolescents do not express bluntly, “shame” is on the stage too. For example most of them stated that “if I was stronger” or “If I was more caring” in which they referred to their selves as weak or not caring.

3.2.5. Feeling Shame

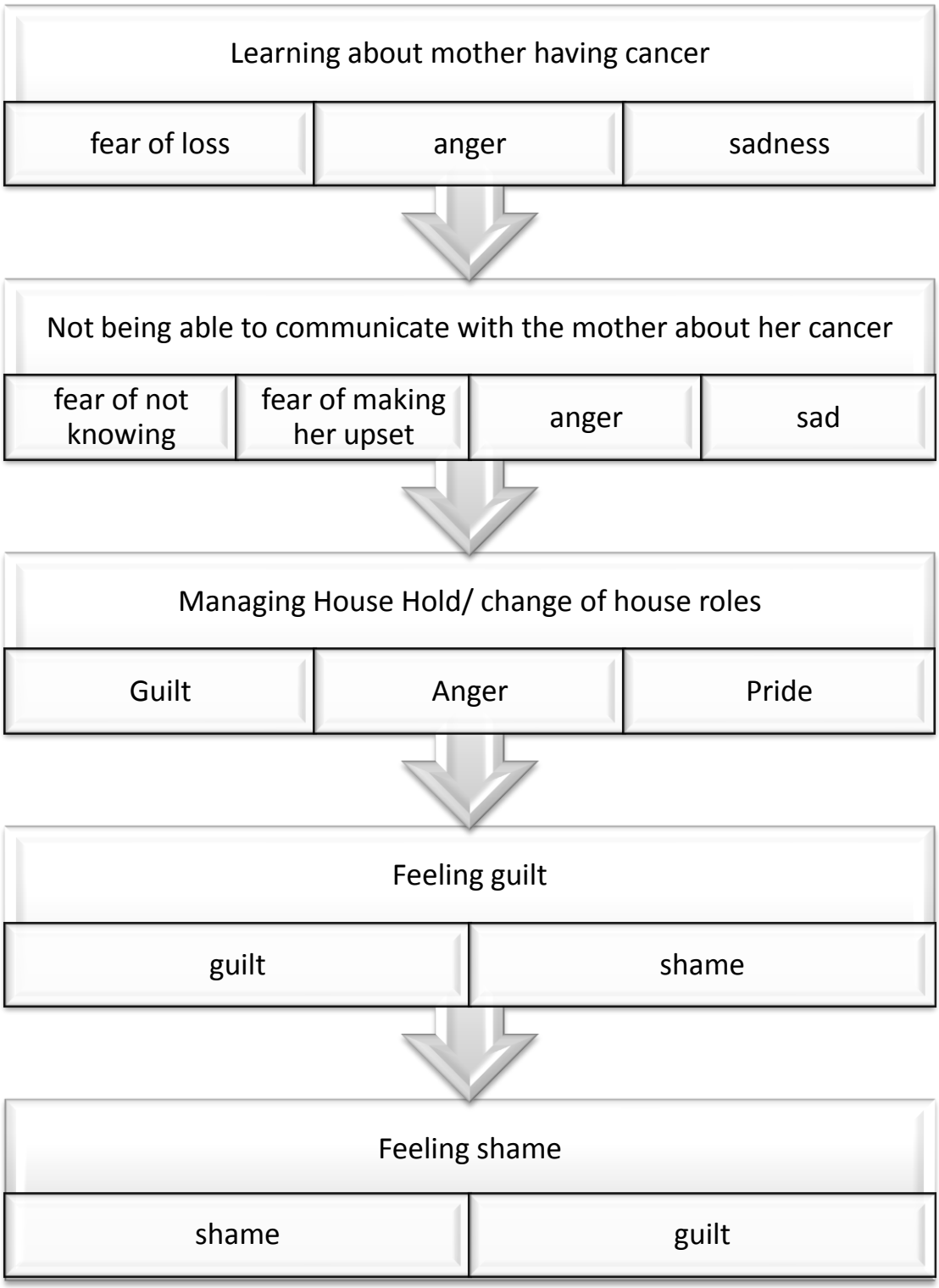
Under this title, the feeling of shame that these adolescents experienced and its effects was discussed.

When 10 adolescents asked the reason of their mothers’ cancer, all of them pointed “stress” as the number one reason. They all believe that their mothers had cancer because of stressful events in their lives, such as conflicted relationship with husband and/or other family members and getting upset about the difficulties too easily. So they believe that one of the reasons that made their mothers stressfull and upset is themselves. All 10 adolescents stated sentences as “If I was a better boy she wouldn’t get sick” or “ If I worked harder at school and got better grades, she wouldn’t be upset” or “If I was a better child my parents wouldn’t get divorced and she wouldn’t be upset”.

All these statements revealed that shame is a profound part of their maternal cancer experience. Even though they do not express the emotion clearly, it can be seperated from guilt.

General results of the interventions indicate that, making interviews with these adolescents bring into light that certain they experience certain emotions throughout the process of their mothers' illness, through the recovery process and also after their mothers get well. Also the results yielded that all these emotions give birth to one another through the process (see figure 1). For example when adolescents first learned about the cancer, the surfaced emotions were fear and sadness. On the other hand, when the recovery process began, adolescents, slowly, brought out the emotions of shame and guilt which were hidden in the depths of their consciousness because they started to evaluate the experience. These adolescents also brought out the emotion of pride while trying to take care of their mothers.

Figure 1: Emotions revealed in the Interventions.



CHAPTER 4

DISCUSSION

In the present study, It was aimed to evaluate if the adolescents with maternal cancer experience emotions of shame and guilt, if these emotions could be differentiate from each other and if cinematherapy and making interventions help capturing and replacing these emotions. In this chapter the results which were obtained in the previous chapter will be evaluated. The two analyses, the analysis of the Sentence Completion Test and analysis of the Interventions, will be compared and the affect of cinematherapy will be discussed. Lastly, the tie between shame, guilt and psychopathology will be set, the forthcoming danger of shame-proneness and guilt proneness will be discussed and a proposal, about how to take precautions in clinical area, will be presented.

4.1. Evaluation of the Results

4.1.1. Analysis of the Sentence Completion Test

In the current study, it was aimed to capture the emotions of shame and guilt with the Sentence Completion Test and to understand if these emotions decrease and/or increase by the interference of external effects such as the film and interventions. It was aimed to analyse the frequency of these stated emotions and see if they changed from session to session. According to the results, it was found that emotions of shame and guilt could be captured and differentiate from one another. This finding was found to be consisted with the literature. According to Lewis (1971), a key difference between shame and guilt focuses on the role of self in the experiences of oneself. She described shame as directly about the *self* which is the focus of evaluation. On the other hand, she

described guilt as the *thing* that has been done or undone is the focus of evaluation. Likewise, in the current study, shame was captured by a sentence which examines the adolescent's attribution about him/herself and guilt was captured by the attribution on something the adolescents did or did not. For example, adolescents who felt shame stated as "If I was a good boy my mother wouldn't have cancer", on the other hand adolescents who felt guilt stated as "If I did not make her upset, she wouldn't have cancer". In the first statement, the adolescent puts an emphasis on him/herself and on his/her self but in the second one, the adolescent blames him/herself because of his/her wrong doing. In the first statement, the focus of evaluation is on the global self but in the second statement it is on a specific behaviour such as Tangney & Dearing (2002) stated.

In the current study, it was also aimed to examine if watching film would increase the frequency of shame and guilt. Sentence Completion Test was successful in capturing the emotions of shame and guilt by using different types of sentences but according to the results, the film the adolescents watched did not make any significant effect on increasing the frequency. On the other hand, the film evoked other emotions rather than shame and guilt: fear and anger. The increase in the frequency of fear and anger in the second session, after the adolescents watched the film was notable. The main reason why the film did not evoke the anticipated emotions was that the adolescents watched the film only for one time and it was not enough to evoke the emotions. Also, the film Pandora's Box was about the relationship of a grandson with his Alzheimer grandmother so it is likely that the adolescents could not identify with the grandson and with the grandmother-grandson relationship in the film. And the

main reason why the film evoked the emotions of fear and anger was because these emotions are closer to surface of consciousness and easier to reach. Since Tyson, Foster, and Jones (2000) defined cinematherapy as a therapeutic intervention which allows clients to visually assess a film's characters' interaction with others, the environment, and personal issues, and develops a bridge from which positive therapeutic movement may be accomplished, it is highly likely that Pandora's Box could not make this affect on the participants, therefore evoking the emotions of shame and guilt was not successful.

The aim of using intervention was to decrease the frequency of shame and guilt and replace them with pride if possible. Like the film effect, the affect of the interventions on participants was not significant either. The main reason might be the timing since the sessions were made in very short time which did not give the participant to evaluate the process. Another reason might be that the Sentence Completion Test given to the participants did not change form session to session so it is highly likely that participants memorized the answers and did not change them. Yet both interventions and the film helped the researcher to build a therapeutic relationship with the participants which led to make a productive interview.

4.1.2. Analysis of the Interventions

Since self-conscious emotions are the feelings which the individual feels as a result of social comparison about one's situation, these emotions (i.e. shame, guilt and pride) are defined as more complex compared to basic emotions (e.g. anger, sadness, joy, fear, disgust, and surprise) and this is due to the fact that self-conscious emotions are based on social concern; they are not automatized like basic emotions forces by survival motive (Johnson-Laird & Oatley, 1989). The starting point of making interventions was to put emphasis on shame and guilt being not automatized emotions and they are hard to capture. The interviews were prepared according to a frame but the main idea was to set the participant free in the precise frame. The aim was to capture self-conscious emotions while making a conversation.

According to the results of the interventions, the emotions of shame, guilt, fear, sadness and anger were revealed. Also shame and guilt were separated from each other according to participants' emphasis on themselves or the thing they did or did not. Another important outcome was the power of interview in building a therapeutic relationship with the participants that gave way to understand their inner world which can be used in clinical area.

The therapeutic relationship which the researcher built with the participants may be a key point for clinicians who deal with adolescents with maternal cancer. Interviews helped these adolescents to overcome their reluctance about talking about their mothers' illness and gave way to a more comfortable atmosphere in which they shared their emotions of shame and guilt. Therefore the interventions in the current study pointed out the importance of

therapeutic relationship which should be built between the therapist and these adolescents and also showed that emotions of shame and guilt can be separated from each other and it is important to track the clues while listening to the adolescents. Interviews also are beneficial instruments to enlighten the presumption of shame-proneness and guilt-proneness and finally, the interviews are beneficial to understand the link between shame and guilt, and psychopathology.

4.1.3. Shame, Guilt and Their Relation to Psychopathology

One of the aims of the present study was to enlighten the link between unresolved shame, guilt and psychopathology and what precautions might be taken in order to prevent psychopathology.

Since self-conscious emotions have been examined as having features contributing to various types of psychopathology which range from emotional disorders to personality disorders (Bradshaw, 1988; Fossum and Mason, 1986; Kohut, 1971; Rodin, Silberstein and Striegel-Moore, 1985; Tangney, Wagner and Gramzow, 1992), it is important to bring out shame and guilt and distinguish between them.

The adolescents with maternal cancer have been experiencing shame from the beginning of the process (If I were a good boy, mum wouldn't have cancer) until after the caner is gone (I am not successful, I am a disappointment to my mother). This is a great burden for an adolescent to handle and it is likely that these adolescents may grow psychopathology. Freud (1915) refers shame as a reaction formation against sexually exhibitionistic impulses. However, the role of shame in psychopathology has been better comprehended with the emergence

of self psychology. H. B. Lewis (1971) mentions that shame sets up conditions in which the boundaries of self become permeable. Lewis (1971) underlies the differential roles of shame and guilt in psychopathology. Moreover H. B. Lewis (1971, 1987) assumes that the proneness to shame and guilt lead to development of specific psychopathological symptoms. This view may point out while shame feeds the tendency to develop an emotional disturbance; guilt leads to tendency to develop thought related disorders. According to Tangney, Wagner and Gramzow, (1992), shame is a vulnerability factor for depression which is an explicit point which should be considered while working with these adolescents as clinicians.

The adolescents with maternal cancer have been experiencing guilt from the beginning of the process (I should have protected my mother) until the end of the recovery time (I should have helped her more) and also after the cancer is gone (I must not upset her otherwise she will get ill again). This burden is a very serious reason for adolescents to grow psychopathology. For example, Freud focuses on guilt, particularly on its connection with obsessional neuroses, masochism, and depression (Tangney & Dearing, 2002). Harder (1995) attempts to define guilt by making the distinction between chronic psychopathological guilt and mild transitory guilt which is common in many people's lives. Similarly, according to Tangney et al. (1992), there exist two types of guilt: Ruminative (anxious) guilt and Non-ruminative (empathic) guilt (Tangney et. al., 1992). The first one refers to pathological guilt and the latter to empathic guilt and it is experienced by everyone. The current study points out that

adolescents with maternal cancer feel guilty because of the deeds they did or did not which can be linked to psychopathology in their adult lives unless resolved.

In fact, for some researchers (Tangney, Wagner & Gramzow, 1992; Ferguson, Stegge, Miller & Olsen, 1999; Andrews, Qian & Valentine, 2002) shame and guilt may have functional and dysfunctional aspects and both have common and specific characteristics which are related to psychopathology. That is why it is important to differentiate these two emotions from one another. Adolescents who feel shame about their mothers' illness might be prone to shame and according to literature, shame-proneness have certain links to psychopathology such as somatisation, obsessive-compulsive traits, paranoid and idiosyncratic ideational styles, proneness to hostility and anger, interpersonal sensivity, both trait and stait anxiety, and depression (Tangney et. al., 1992). However, guilt-proneness is generally demonstrated as moral rather than pathological. Therefore, it is found to be inversely related to hostility and danger, phobic anxiety and depression. On the other hand, guilt is related to psychopathology only when it is fused with shame or when it reflects general negative affect. According to Lewis (1992), shame-free guilt is a favourable emotion but to make guilt shame-free, the lines between shame and guilt should be drawn.

According to the literature, it is obvious that shame and guilt have a certain relationship with psychopathology and adolescents who experience these emotions, unless resolved, may become prone to shame and/or prone to guilt. So the most important task for a clinician who comes across with a client whose mother has or had cancer is to seek for the emotions of shame and guilt. Then

the therapist may differentiate these emotions and work on replacing them with pride or/and replace them with shame-free guilt.

4.2. Strengths and Implications of the Study

The present study's most important strength could be considered as being the only research based on the emotions of shame and guilt adolescents with maternal cancer, experience. In particular, the literature mostly focused only on distinguishing between these two emotions (Tangney & Dearing, 2002). The current study both focuses on the differentiation and the link of shame and guilt with psychopathology. Another strength of the study is that it tries to show the forthcoming danger these adolescents are in, because unresolved emotions of shame and guilt may cause psychopathology. Since oncology services of the hospitals in Turkey, newly, focused on the psychological aspect of the illness, this study puts an emphasis on the point that cancer is not a one-person disease; it affects the whole family, especially the children.

One other strength of the study is that it uses a qualitative technique which allowed the researcher to deeply examine the emotions of shame and guilt. The interventions that were made with the participants allowed the researcher to build a therapeutic relationship with the participants which led the participants to reveal the emotions of shame and guilt more easily. The current study is also the first study which used a film to evoke the emotions of shame and guilt.

Furthermore, the present study is based on the fact that adolescents go through difficult times when their mothers are sick and they do not have any

support. One implication of the study is that it expresses the need for a social and psychological support for these adolescents is a must. It also brings light into the clinical area that these adolescents are in danger of growing psychopathology in case their emotions of shame and guilt remain unresolved. This study provides beneficial information about the state of mind these adolescents are in.

4.3. Limitations of the Study and Suggestions for the Future Studies

Even though the present study reveals important findings for the clinical area and for the literature of self-conscious emotions, there are many limitations.

Most prominent limitation is the number of the participants. 10 participants could not give a sufficient perspective on the emotions these adolescents experienced. For further studies, more participants should be involved. Also the gender difference could be included in the study. For further research it is recommended to examine the emotions of females with maternal breast cancer.

One limitation came from the selection of the film, which did not evoke the anticipated affect on the participants. For further studies, if a film to be selected, it should reflect a closer relationship to the relationship of an adolescent and mother who has cancer or another illness. Furthermore the participants watched the film for only one time which was not enough to evoke the emotions of shame and guilt so for further studies, it is recommended to watch more than one film in order to build the therapeutic relationship with the participants over the movie they watched.

The present study also revealed the emotions of fear and anger, for further studies working and resolving those emotions, and then dealing with shame and guilt is recommended.

Although making interventions with the participants provided a clearer view of the emotions these adolescents experienced, interviews were set by the observations of the researcher. For further studies, more framed interventions will give clearer view to the researchers.

Another limitation comes from the design of the study. Accordingly, there were no control groups in the current study; a group of adolescents whose mothers are healthy should be added. The outcome of the applications monitored merely based on observations of the researcher and on the participants' responses, which is an important limitation. Thus, future research should evaluate the results of both the Sentence Completion Test and the interventions driven from a more heterogeneous sample; a more in-depth qualitative analysis is recommended for further research.

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APPENDIX A: APPLICATION FORM

Değerli Katılımcı;

Bu çalışma, Orta Doğu Teknik Üniversitesi Psikoloji Bölümü yüksek lisans öğrencisi Lale Belgü Kaçmaz tarafından, Klinik Psikoloji Yüksek Lisans bitirme tezi kapsamında yürütülmektedir. Bu çalışmanın amacı, kanser hastası olan annelerin çocuklarındaki duyguları araştırmaktır. Çalışmaya katılım tamamen gönüllülük esasına dayanmaktadır. Çalışmadaki sorularda kesinlikle kimlik belirleyici bilgiler istenmemektedir ve rahatsızlık verecek sorular bulunmamaktadır. Çalışmayı istediğiniz zaman bırakmakta serbestsiniz. Bununla birlikte, sorulara samimi cevaplar vermeniz araştırmada elde edilen sonuçların geçerli ve güvenilir olmasını sağlayacaktır. Verdiğiniz tüm cevaplar gizli tutulacak ve elde edilen bilgiler sadece araştırma amaçları doğrultusunda kullanılacaktır. Ayrıca çalışmayla ilgili her türlü sorularınız cevaplandırılacaktır.

Çalışma hakkında bilgi almak için ODTÜ Klinik Psikoloji yüksek lisans öğrencisi L. Belgü KAÇMAZ (Tel: 0535 4975759; e-posta: e168623@metu.edu.tr) ile iletişim kurabilirsiniz.

Katılımınız için teşekkür ederiz.

Bu çalışmaya tamamen gönüllü olarak katılıyorum ve istediğim zaman yarıda kesip çıkabileceğimi biliyorum. Verdiğim bilgilerin bilimsel amaçlı yayımlarda kullanılmasını kabul ediyorum. (Formu doldurup imzaladıktan sonra uygulayıcıya geri veriniz).

Adı Soyadı Tarih İmza

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APPENDIX B: PARENT CONCENT FORM

Sayın Veli,

Bu araştırma Orta Doğu Teknik Üniversitesi Psikoloji Bölümü Klinik Psikoloji Yüksek Lisans öğrencisi Lale Belgü Kaçmaz tarafından yürütülmektedir. Araştırmanın amacı kanserli annelerin çocuklarındaki duyguları incelemektir. Bu amacı gerçekleştirebilmek için çocuklarınızın bir anketi doldurmalarına, Pandora'nın Kutusu isimli filmi izlemelerine ve onlarla yapılacak olan bireysel görüşmelere katılmalarına izin vermenize ihtiyaç duymaktayız.

Katılmasına izin verdiğiniz takdirde çocuğunuz anketi araştırmacının gözetiminde dolduracak, filmi onuna birlikte izleyecek ve birlikte bireysel görüşme yapacaklardır. Çocuğunuzun cevaplayacağı soruların onun psikolojik gelişimine olumsuz etkisi olmayacağından emin olabilirsiniz. İzlenecek film ise yaş sınırı bakımından uygun olarak seçilmiştir. Çocuğunuzun dolduracağı anketlerde cevapları kesinlikle gizli tutulacak ve bu cevaplar sadece bilimsel araştırma amacıyla kullanılacaktır. Bu formu imzaladıktan sonra hem siz hem de çocuğunuz katılımcılıktan ayrılma hakkına sahipsiniz.

Çocuğunuzun çalışmaya katılmasına izin vererek bize sağlayacağınız bilgiler çocukların duygusal gelişimini etkileyen faktörlerin saptanmasına önemli bir katkıda bulunacaktır. Araştırmayla ilgili sorularınızı aşağıdaki e-posta adresini veya telefon numarasını kullanarak bana yöneltebilirsiniz.

Saygılarımla,
Psikolog L. Belgü Kaçmaz
Klinik Psikoloji Yüksek Lisans
Orta Doğu Teknik Üniversitesi, Ankara
Tel: 0535 7052125
e-posta: e168623@metu.edu.tr

Lütfen bu araştırmaya katılmak konusundaki tercihinizi aşağıdaki seçeneklerden size en uygun gelenin altına imzanızı atarak belirtiniz ve bu formu araştırmacıya teslim ediniz.

A) Çocuğum .....'nın katılımcı olmasına izin veriyorum. Çalışmayı istediğim zaman yarıda kesip bırakabileceğimi biliyorum ve verdiğim bilgilerin bilimsel amaçlı olarak kullanılmasını kabul ediyorum.

Baba Adı-Soyadı..... Anne Adı-Soyadı.....

İmza ..... İmza.....

B) Çocuğumun .....'nın katılımcı olmasına izin vermiyorum.

Baba Adı-Soyadı..............................	Anne Adı-Soyadı.............................
İmza	İmza ....

APPENDIX C: DEMOGRAPHICS FORM

Yaş : _____
Cinsiyet: Kadın ( ) Erkek ( )
Doğum Yeri:
Eğitim Durumu:
Nerede Kalıyorsunuz? a) Kendi evimde
b) Kirada
c) Yurtta
d) Özel yurtta
Kiminle yaşıyorsunuz? a) Ailemle
b) Arkadaşlarımla
c) Akrabalarımla
d) Yalnız
Ailenizin eğitim durumu:

Anne: a) Okur-yazar değil
b) Okur-yazar veya ilkokul terk
c) İlkokul mezunu
d) Ortaokul mezunu
e) Lise mezunu
f) Üniversite
g) Master/ doktora

Baba: a) Okur-yazar değil
b) Okur-yazar veya ilkokul terk
c) İlkokul mezunu
d) Ortaokul mezunu
e) Lise mezunu
f) Üniversite
g) Master/ doktora

APPENDIX D: SENTENCE COMPLETION TEST-A

Aşağıda kendinizle ilgili cevaplandıracağınız sorular yer almaktadır. Lütfen aklınıza ilk gelen düşünceyi ya da kelimeyi bırakılan boşluğa yazınız.

Annem ilk hastalandığında ……..... hissettim.

İlk saçları döküldüğünde……. .....hissettim.

Göğsünü aldıklarında/ameliyat olduğunda ……..... hissettim.

Hastalandığı için ona/onu …… .....

Hastalanmasaydı ……..... olurdu.

Annem hasta oldu çünkü ben…….. .....

Bence bu hastalık……. .....için / den dolayı oluyor.

Ben ……..... olsaydım annem hastalanmazdı.

Şimdi olsa anneme ……..... yardımcı olurdum.

APPENDIX E: SENTENCE COMPLETION TEST-B

Aşağıda hem kendinizle hem de filmle ilgili cevaplandıracağınız sorular yer almaktadır. Lütfen aklınıza ilk gelen düşünceyi ya da kelimeyi bırakılan boşluğa yazınız.

Annem ilk hastalandığında ……..... hissettim.

İlk saçları döküldüğünde……. .....hissettim.

Göğsünü aldıklarında/ameliyat olduğunda ……..... hissettim.

Hastalandığı için ona/onu …… .....

Hastalanmasaydı ……..... olurdu.

Annem hasta oldu çünkü ben…….. .....

Bence bu hastalık……. .....için / den dolayı oluyor.

Ben ……..... olsaydım annem hastalanmazdı.

Şimdi olsa anneme ……..... yardımcı olurdum.

Anneannesinin hasta olduğunu öğrendiğinde Murat ……

.....hissetti.

Murat…….. .....hissettiği için anneannesinin gitmesine izin verdi.

Anneannesinden ayrılmak Murat'a/ Murat'ı …… .....hissettirdi.

Benim annemle olan ilişkim Murat'a göre

daha…….....

.

Ben Murat olsaydım anneannemi /anneanneme …….....

Bu filmdeki aile benim aileme göre daha…….....