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Exploring Shame and Guilt in HIV-Positive Women in Southern India

Manuscript submitted in partial fulfillment of the requirements for Psy.D.

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Author Note

This research was conducted under the guidance of research mentor Courtney Welton-Mitchell and with support from the University of Denver's International Disaster Psychology (IDP) program, including Judith Fox. Data used in this manuscript was collected by Kendall Sauer, Sara Anderson, Meghan Hunter, Rachel Gray in collaboration with the C.A.R.E. Center Namakkal and Dr. N. M. Samuel during the summer of 2013. The data for this manuscript was analyzed by Kendall Sauer and was used previously in a published article (Sauer, Welton-Mitchell, Anderson, & Samuel, 2015). Correspondence concerning this article should be sent to Mitra Lebastchi at [Mitra.Lebastchi@du.edu](mailto:Mitra.Lebastchi@du.edu).

## ABSTRACT

Limited research exists examining shame and guilt among HIV positive populations and across cultural contexts. This study addresses this gap in the literature by considering shame and guilt, and potential associations with mental health symptoms, among a sample of 20 HIV positive women in Southern India. Results indicate that most women experienced high levels of shame and guilt, based on responses to items from an adapted version of the State Shame and Guilt Scale (Marschall, Saftner, & Tangney, 1994). Although correlations were not significant between shame and PTSD or depression, guilt was significantly correlated with both. Future research should focus on more rigorous approaches to adapting this or alternative measures of shame and guilt to a specific cultural context, especially considering the potential clinical utility.

## INTRODUCTION

Shame has been described as a painful emotion involving feelings of powerlessness that can make a person want to disappear (Lewis, 1971). Shame has further been explained as an emotion directed towards the whole *self*, involving components of anger, anxiety and disgust (Gilbert, 2002; Allan & Goss, 2009). In contrast, *guilt*, is typically thought of as an emotion directed towards one's specific *behavior* (Lewis, 1971). It has been suggested that feelings of guilt can typically be resolved by changing one's behavior, seeking forgiveness and making amends (Tangney, 1995), whereas shame may be harder to address. Some have suggested that shame can be viewed as more pathological than guilt based on the view that shame is a "global punitive judgment of the self" whereas guilt is "associated with motivation toward reparative action" (Averill, Diefenbach, Stanley, Breckenridge & Lusby, 2001). Despite the terms at times being used synonymously, numerous studies have supported this distinction between shame and guilt (e.g., Lindsay-Hartz, 1984; Niedenthal, P. M., Tangney, J., & Gavanski, I., 1994; Tangney, J., Stuewig, J., & Mashek, D. J., 2007).

Several studies indicate that shame plays a role in the development of PTSD symptoms. For example, shame has been associated with PTSD in adult victims of various violent crimes, adult women with a history of childhood sexual abuse, women with a history of psychological abuse, and war veterans, among others (Andrews, Brewin, Rose, & Kirk, 2000; Brewin, Street & Arias, 2001; Wong & Cook, 1992; You, Talbot, He & Conner, 2012). In research with children, feelings of abuse-related shame have been implicated in the development and maintenance of PTSD symptoms up to six years after the abuse (Feiring & Taska, 2005). Shame also appears to be predictive of difficulty regulating anger, depression and general dysphoria that is resistant to

change (Fletcher, 2011; Finkelhor & Browne, 1985).

Guilt also appears to be linked to various mental health symptoms, including PTSD (e.g. Beck et al., 2011; O'Connor, Berry, & Weuss, 1999; Orth, Berking, & Burkhardt, 2006; Tangney, Wagner & Gramzow, 1992). In a meta-analysis of over 100 published articles and several unpublished databases, guilt was associated with depressive symptoms ( $r = .28$ ), as was shame ( $r = .43$ ) (Kim, Thibodeau, & Jorgensen, 2011). Given this, it is important to understand the prevalence and correlates of both guilt and shame in specific populations, especially those at risk for experiencing potentially debilitating mental health symptoms.

### **Shame, guilt and HIV**

Shame appears to be common in persons living with HIV, including those who have received an AIDS diagnosis. Multiple studies have reported a medium to large effect size for the relationship between depressive symptoms and shame in people living with HIV (Bennett, Traub, Mace, Juarascio, & O'Hayer, 2016; Li et al., 2010; Rodkjaer, Laursen, Balle, & Sodemann, 2010). Research has found shame in those who are HIV-positive to be predictive of risky sexual behavior (Sikkema, 2009; Neufeld et. al., 2012), non-adherence to HIV medications (Konkle-Parker, Erlen, & Dubbert, 2008), perceived lower quality of life (Pearsons et. al., 2010; Neufeld, 2012), and increased production of 'stress-hormones' such as cortisol, in social situations (Gruenwald, Kemeny, Aziz & Fahey, 2004). This association between shame and cortisol production is particularly important, because persons living with HIV with higher cortisol levels tend toward higher viral loads, more severe fatigue, more depression, and more state and trait anxiety (Barroso et. al., 2006).

Research also indicates that people living with HIV, including those diagnosed with AIDS,

frequently experience guilt. Studies suggest that guilt and shame scores may be higher for those living with HIV than for those with other chronic medical conditions such as diabetes and cancer (Cantisano, Rime, & Munoz Sastre, 2013). Guilt has also been associated with decreased scores on general measures of mental and physical health for who are HIV-positive and diagnosed with AIDS(Cantisano, Rime, & Munoz Sastre, 2015).

### **Shame, guilt and culture**

Shame and guilt have been found across many different cultural contexts. Results of a study examining shame and guilt in 27 countries indicated both emotions were present across all cultural groups examined (Matsumoto, Kudoh, Scherer, & Wallbott 1988; Walbott & Schere, 1986, 1995). Other more recent research has found shame to be a common in response to perceived failure in over 30 countries (Tracey & Matsumoto, 2008). Despite the seemingly universal nature of these emotions, research indicates that there may be cultural variability in how emotions such as shame and guilt are *experienced*, and that the distinction between the two emotions may be more or less pronounced across different cultural contexts, such as individualist compared to collectivist settings (Li, Wang, & Fischer, 2004; Walbott & Schere, 1995; Wong & Tsai, 2007).

In addition, some cultures may be more shame-prone than others. In one study, Japanese university students were more shame-prone than similar students in the United States and the United Kingdom (Sznycer et al., 2012). When shame and guilt were studied in Indian and Italian undergraduate students, results indicated that Indian students experienced shame as more intense and longer lasting than their Italian counterparts (Anolli & Pascucci, 2005). Indian students also scored significantly higher in both guilt-proneness and shame-proneness compared to Italians

(Anolli & Pascucci, 2005). This may be explained in part by research indicating that failure to meet highly valued cultural ideals can lead to a sense of inadequacy (Greenwald & Harder, 1998). Among women in Tamil Nadu, India, higher levels of education appeared to be buffer against shame, with higher education levels associated with less shame (Mahalingam, & Jackson, 2002).

There is limited research examining the prevalence of shame and guilt among people living with HIV in India. This may be because much shame research has been “subsumed within measures of internalized stigma, an imprecise construct with varied definitions in the HIV literature” (Bennett, Traub, Mace, Juarascio, & O'Hayer, 2016, p. 87). Not all measures of internalized stigma take shame into account (Bennett, Traub, Mace, Juarascio, & O'Hayer, 2016). A few studies have however, emphasized links between internalized stigma and shame, with an emphasis on the potential for such emotions to adversely affect utilization of HIV services - in India and elsewhere (Kumar et al, 2015; Thomas et al, 2005; Thomas et al, 2012). Despite this, it is preferable to measure shame as a separate construct in order to adequately understand behavioral and other correlates of this emotion in women living with HIV.

Understanding shame among HIV-positive populations in specific cultural contexts also has important clinical implications. Negative self-image has been associated with an increased risk for depression for HIV-positive women (Charles et al., 2012), and shame has also been associated with depression (Mahalingam, & Jackson, 2002), both among populations in Tamil Nadu, India. Given the potential for feelings of guilt and shame among those in India living with HIV, and diagnosed with AIDS, to be high, and the possibility of such feelings to be associated with mental health outcomes, further study is warranted.

HIV-positive women may have a more difficult time in India than many men. Research

suggests that gender, HIV and stigma can interact, leading HIV positive women in places like Tamil Nadu, India to experience intense feelings of guilt (Van Hollen, 2010). In one study, the HIV-positive status of women in Tamil Nadu was reportedly viewed as “a transgression of morality” in private interactions. Women reported experiencing significant blame from family members for being HIV-positive, especially from in-laws (Van Hollen, 2010). This work suggests that HIV positive women in Tamil Nadu struggle with self-conscious emotions such as shame and guilt. Some literature indicates that reducing guilt continues to be a primary goal of support groups serving HIV-positive women in such locations (Van Hollen, 2010).

### **Measuring shame and guilt**

Shame and guilt can manifest as emotional *states*, often referred to as moods (feeling shame or guilt in the moment), or *traits* (a disposition or proneness to experiencing shame). While there are many dispositional measures that get at traits, there are only a few state measures of shame and/or guilt (Tangney & Dearing, 2002). It is important to consider state measures of shame and guilt, especially for persons living with HIV. Measuring feeling shame or guilt in the moment allows for various contextual factors potentially contributing to guilt and shame in a given setting, rather than relying solely on individual predisposition. In addition, the assumption that shame or guilt is static doesn't acknowledge the important role of social context, and the typical fluctuation in most emotional states.

There have been a few efforts to develop a standard measure of state-related shame and guilt. For example, the State Shame and Guilt Scale (SSGS) was developed to measure state shame, guilt and pride (Marschall, Saftner, & Tangney, 1994). It is important to consider to what extent such state-based shame and guilt measures function in a variety of cultural contexts,

especially considering the potential for these constructs to have clinical implications, such as maintenance of depressive symptoms. .

### **Current study**

The current study explores the relationship between shame, guilt, and symptoms of PTSD and depression in a sample of HIV-positive women seeking supportive health services in southern India. Little research has been conducted specifically measuring HIV-related shame and guilt outside of Western countries, or in more collectivist cultural settings such as India. Such research is important for many reasons, including because guilt and shame can affect help seeking behaviors, thereby putting persons living with HIV at greater risk for negative outcomes in terms of both overall health and psychological well-being. Understanding these constructs also has clinical utility in that shame and guilt may be contributing to the development of PTSD and depression and influencing treatment response.

The State Shame and Guilt Scale (SSGS) has been used for the purpose of this research, in hopes of determining whether it is a good fit for use with HIV affected women in Southern India, and what it can tell us about the potential relationship between shame, guilt, PTSD and depression. It is hypothesized that this population will experience high levels of both state guilt and shame. Secondly, it is hypothesized that both state shame and guilt will be correlated with depressive symptoms and PTSD.

## **METHODS**

### **Participants**

Data was collected for this study as part of a larger investigation into the experiences of women living with HIV/AIDS in Tamil Nadu, India (see 1 - Sauer, Welton-Mitchell, Anderson, & Samuel, 2015; 2 - Hunter, Gray, Welton-Mitchell & Samuel, 2015; both publications provide

details on the full study). Data was collected by a group of Masters in International Disaster Psychology (MAIDP) students from the Graduate School of Professional Psychology at the University of Denver. For the research component, MAIDP students were working under the remote supervision of the same mentor who provided support for this doctoral paper. MAIDP students collaborated with a local non-governmental organization (NGO) in Namakkal India, The C.A.R.E. Foundation. C.A.R.E. provides health services to women and children living with HIV and AIDS in a rural part of Namakkal, India. Research procedures were approved both by the institutional review board at the University of Denver and the corresponding research ethics board in India before data collection began. All data was collected in rural Tamil Nadu, India during the summer of 2013.

### Procedures

As part of a larger study (see Sauer et al., 2015; Hunter, Gray, Welton-Mitchell & Samuel, 2015), participants were visited twice over the course of the study and answered a 102-item questionnaire that included the State Shame and Guilt Scale (SSGS).<sup>1</sup> Before data collection all items were translated into Tamil by a local university graduate and then back translated to English by the research team comprised of U.S. researchers and local staff. Items were individually reviewed to ensure that the intended meaning of the items was captured and items were culturally appropriate for the participants.

Participants were recruited through an information session provided to all clients utilizing services through the local NGO. During this information session, possible participants were able

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<sup>1</sup> For the purposes of this manuscript, only data from the SSGS collected during the first visit has been included. T-test analysis showed no significant difference between shame and guilt total scores at t1 and t2 ( $t=-.541$  (38),  $P=.655$ ).

to ask questions about the study and meet the research team. A sample was randomly selected and telephone calls were made following the information session to assess for desire to participant in the study. In the end, 20 participants were recruited. Consent was discussed and confirmed by signature or thumbprint depending on literacy, as was culturally appropriate. Consent was discussed before the participants completed the structured interviews. Participants were asked to ‘opt-in’ to minimize the potential for coercion.

In the context of the larger study, “structured interviews were used to collect information about mental health symptoms, HIV-related stigma in the form of negative social reactions, social support, interpersonal violence and exposure to other adverse events, shame, guilt, coping skills, HIV transmission knowledge, and demographics (e.g. religion, age, marital status, number of children)” (Sauer et al., 2015, p. 86). The shame and guilt measure was administered following completion of trauma history, PTSD and depression checklists.

In order to reduce the inconvenience of traveling for the participants, interviews were conducted at personal residences in a private area. The one-hour interviews were planned for previously agreed upon dates and times. Participants were compensated for their time with a 2-kilogram bag of rice worth approximately \$2.00 (Sauer et al., 2015).

## Measures

**Participant demographics:** The following information was collected: age, marital status, number of children, economic resources, education, employment status, and religion (Sauer et al., 2015).

**Shame and Guilt:** The State Shame and Guilt Scale (SSGS) was developed to measure

state shame, guilt and pride (Marschall, Saftner, & Tangney, 1994). The SSGS has been utilized to measure cortisol levels in relation to state shame (Gruenwald et. al., 2004), to monitor effective treatment targeting shame with persons diagnosed with Borderline Personality Disorder (Rizvi & Linehan, 2005), to distinguish healthy and unhealthy perfectionism in undergraduate students (Fedewa, Burns, & Gomez, 2005; Stoeber, Harris & Moon, 2007; Stoeber, Kempe, & Keogh, 2008), and to evaluate the role of shame, self-blame and stigma in adjustment in cancer patients (Else-Quest et. al., 2009). The SSGS has been translated into Spanish and used in the Dominican Republic to study shame, guilt and health outcomes (Cantisano, Rimé, & Munoz Sastre, 2015). The SSGS has shown adequate test-retest reliability (Hall, & Fincham, 2008). While this measure has not been validated in this specific cultural context, it has been used outside of the research lab, in naturalistic settings (Gruenewald et al., 2004; Tangney and Dearing, 2007).

The SSGS consists of 3 subscales, shame, guilt and pride, 5 items each, totaling 15 items. Participants are asked to rate how they are feeling currently on a 5-point scale from 1 = *not feeling this way at all*, to 5 = *feeling this way very strongly*. The following instructions were read allowed to participants prior to administering the measure: “The following are some statements which may or may not describe how you are **feeling right now**. Please rate each statement based on how you are feeling **right at this moment**.” An example of a shame item is *I feel like I am a bad person*. An example of a guilt item is *I feel bad about something I have done*. See Table 1 for all items. The Cronbach’s alpha for the shame subscale was 0.64. The Cronbach’s alpha was low (0.36) for the guilt subscale; however these scale items were retained and have been reported here given the exploratory nature of this study (Sauer et al., 2015).

**Trauma Exposure, including interpersonal violence:** An adapted 5-item version of the Life Events Checklist (Blake et al., 1995) was used to measure childhood and adult exposure to trauma. The item asking about “life threatening illness,” was removed because HIV-infection is a criterion for receipt of services at the local NGO where participants were recruited. Participants were asked about exposure to the following specific events: *natural disasters, motor vehicle accidents, physical assault by a family member (e.g. partner, husband, mother-in-law), physical assault by someone outside of the family, and sexual assault* (Sauer et al., 2015).

**Depression:** The Hopkins Symptom Checklist (HSCL-25) is a self-report scale, which measures symptoms of anxiety and depression that has been validated for use with a variety of cultural groups (Klein et al., 2001). The 15-item depression subscale was used in this study, with response options from 1 = *not at all* to 5 = *extremely*. Based on suggestions from local NGO staff, one researcher-created somatic symptom item was added to the scale: *Headaches or other pain in my body when thinking about the problems in my life*. Additionally, an item about sexual interest or pleasure was dropped due to the difficulties local staff had administering the item. Good internal consistency was found for all items with Cronbach’s alpha = 0.89 (Sauer et al., 2015).

**PTSD:** The Harvard Trauma Questionnaire (HTQ) is a self-report measure developed for research and assessment of trauma symptoms in Indochinese refugees (Mollica et al., 1992). Many versions of the HTQ have been validated for use with Cambodian, Laotian, Vietnamese, Arabic, Farsi, Serbo-Croatian, and Russian-speaking populations (Klein et al., 2001). Following the Tsunami in 2004, the HTQ was used for both research and screening in Tamil Nadu (Kumar et al., 2007). Based on recommendations of cultural appropriateness, 13 items from the HTQ

were selected for use within this study. Participants were asked to respond based on *problems people may experience after a stressful event and how much these problems affected [them] in the past week*. Responses ranged from 1 = *not at all* to 4 = *extremely* for all items. Internal consistency was good with Chronbach's alpha being 0.83 (Sauer et al., 2015).

## RESULTS

Data were analyzed by the research team using Statistical Package for the Social Sciences (IBM, SPSS Statistics, 20.0 and 21.0). Prior to analysis, variables of interest were examined for violations of statistical assumptions (e.g., skew, kurtosis, extreme outliers). No outliers were in need of modification. Descriptive statistics were run on variables of interest. Pearson-correlations were used to explore associations between mental health symptoms (PTSD, depression) and shame and guilt (see Sauer et al., 2015 for full analyses).

**Participants** Study participants were twenty (n=20) randomly selected women receiving services at the clinic. All were HIV positive, with most diagnosed with AIDS, and utilizing clinic services at the time of the research. The average age of participants was 42 years old (M=42.5 years; SD=7.10; range 28-55). The majority of women indicated they were Hindu (n=17), with two indicating they were Christian (n=2). All participants indicated they were married, but at the time of data collection only 15% (n=3) were living with their husbands, 25% (n=5) were separated from their husbands and 60% (n=12) reported being widowed. Seventy-five percent of women (n=15) indicated that they had completed 6 years of education or less (M=4.80; SD 3.72; range 0-10). Although 75% of women (n=15) described being at least partially employed, 90% (n=18) indicated that they had "less than or much less than" others in

their community. Eighty percent (n=16) of participants endorsed a history of interpersonal violence. Sixty-five percent (n=13) reported being physically assaulted by a family member, 35% (n=7) endorsed being physically assaulted by a non-family member and 25% (n=5) stated they had experienced a sexual assault.

**Shame and Guilt.** For the purposes of this study only the shame and guilt subscales were used for data analysis (the pride subscale was not relevant to the research). As mentioned in the previous section, the reliability of the SSGS Shame subscale was found to be acceptable with an internal consistency of  $\alpha = .64$ . The reliability of the SSGS Guilt subscale however was found to be low with an internal consistency  $\alpha = .36$ . As noted already, given the exploratory nature of this study, results from the guilt scale have still been reported and interpreted here. The Shame subscale had a mean severity score of  $M = 14.26$ ,  $SD = 4.51$ , and range 9-17 (out of a possible 5-25). The Guilt subscale had a mean severity score of  $M = 17.11$ , standard deviation of  $SD = 4.12$  and range of 7-20 (out of a possible 5-25).

When this measure was developed with a U.S. population of University students, the scores for shame and guilt subscales were significantly lower (shame:  $M = 6.71$   $SD = 2.6$ ; guilt:  $M = 7.39$   $SD = 2.87$ ). Please refer to Table 1 for further details of item descriptives. Table 1 also highlights some of the challenges associated with cross-cultural translation and back-translation of items, implications of which will be elaborated in the discussion section.

**TABLE 1.**

*Original SSGS Shame and Guilt Items, Back Translation from Tamil, and Mean (SD)*

| Item | SSGS Measure | Back Translation from Tamil | Mean (SD) |
|------|--------------|-----------------------------|-----------|
|------|--------------|-----------------------------|-----------|

|     |   |  |             |
|-----|---|--|-------------|
| 2   | I want to sink into the floor and disappear.            | I feel that I am drowning in this problem.   | 2.75 (1.68) |
| 3   | I feel remorse, regret.                                 | I feel stressed and worried.   | 4.40 (.88)  |
| 5   | I feel small.   | I feel very small.   | 3.95 (1.23) |
| 6   | I feel tension about something I have done.             | Though I have completed work, I don't feel satisfied.                                    | 3.55 (1.43) |
| 8   | I feel like I am a bad person.                          | I feel I am a filthy, bad person.  | 1.90 (1.41) |
| 9   | I cannot stop thinking about something bad I have done. | I am getting recurrent thoughts of bad things I have done. I cannot stop these thoughts. | 2.80 (1.67) |
| 11* | I feel humiliated, disgraced.                           | I am to be forgiven.   | 2.31 (1.40) |
| 12  | I feel like apologizing, confessing.                    | I don't have any status. I am a low person.  | 2.70 (1.81) |
| 14  | I feel worthless, powerless.                            | I am comfortless and I am not worthy.  | 2.35 (1.60) |
| 15  | I feel bad about something I have done.                 | I feel sorry for the things I have done.   | 3.74 (1.76) |

Note \* reverse scored due to translation difficulties. Scale responses range from 1-5.

**Trauma exposure, interpersonal violence:** The majority of women reported multiple types of trauma exposure and on average endorsed 1.5 events (median = 2; range = 0-4). The most commonly endorsed form of trauma (65%) was *physical assault by a close family member* (e.g. partner, husband, mother-in-law). Furthermore, many reported having experienced *physical assault by a stranger* (35%), an *unwanted sexual experience* (26%), a *motor vehicle accident* (15%), or *exposure to natural disaster* (10%). Most participants (80%) had experienced

interpersonal abuse by a family member or stranger. Most incidents were reported as happening during adulthood (80%), with 20% happening during childhood. A minority of participants (15%) did not endorse any of the adverse events listed (Sauer et al., 2015).

**Depression:** In populations in which it has been normed and validated, an average score of  $>1.75$  on the HSC represents a diagnosis of clinical depression. Ninety-four percent of respondents ( $n=18$ , 2 missing cases) had an average score  $>1.75$  ( $M=3.32$ ;  $SD=0.71$ ). Calculation of scores reflected the excluded items. However, diagnostic cut-offs have not been validated for this population so the range of scores were examined (range 19-54;  $M = 43$ ;  $SD = 9.27$ ) and split into groups to reflect mild, moderate and severe symptoms. Most participants endorsed severe symptoms (61%), while 28% endorsed moderate symptoms and 11% endorsed mild symptoms (Sauer et al., 2015). For the purpose of analysis examining the relationship between shame, guilt and depression a continuous variable has been used instead of diagnostic cut-offs or high, moderate, low categorical approaches.

**PTSD:** On the HTQ, 83% of women ( $n = 18$ ) scored above the traditional cutoff of 2.5 indicating a high incidence of PTSD symptoms in this population ( $M = 2.91$ ;  $SD= 0.58$ ). Results should be interpreted with caution because this measure has not been normed or validated with this population and cut off scores may be misleading. Accordingly, the lower and upper thirds of the scores were calculated, corresponding with mild and severe symptoms. Most participants endorsed severe symptoms (56%), while 33% endorsed moderate symptoms and 11% endorsed mild symptoms (Sauer et al., 2015). For the purpose of analysis examining the relationship

between shame, guilt and PTSD a continuous variable has been used instead of diagnostic cut-offs or high, moderate, low categorical approaches.

**Correlations:** There were no significant correlations between shame and depression or PTSD. Guilt was significantly correlated with PTSD and depression. Please refer to Table 2 for details. Post-hoc chi-square analyses indicated that there were no significant differences between shame and guilt scores related to the type of trauma reported by participants on the Life Events Checklist.

**TABLE 2.**

*Correlations between Guilt, Shame, Trauma History, PTSD and Depression*

| Scale      | Guilt         | Shame         | Trauma       | PTSD          | Depression    |
|------------|---------------|---------------|--------------|---------------|---------------|
| Guilt      | 1             | <b>.806**</b> | .211         | <b>.639**</b> | <b>.481*</b>  |
| Shame      | <b>.806**</b> | 1             | .129         | .373          | .172          |
| Trauma     | .211          | .129          | 1            | .258          | <b>.461*</b>  |
| PTSD       | <b>.639**</b> | .373          | .258         | 1             | <b>.821**</b> |
| Depression | <b>.481*</b>  | .172          | <b>.461*</b> | <b>.821**</b> | 1             |

Note. Guilt = SSGS guilt subscale; Shame = SSGS shame subscale; Trauma = trauma exposure as measured on the adapted Life Events Checklist; PTSD = trauma symptoms as reported on the adapted Harvard Trauma Questionnaire (HTQ); Depression = reported symptoms of depression and anxiety on the adapted Hopkins Symptom Checklist (HSCL-25)

\*  $p < .05$

\*\*  $p < .01$

## DISCUSSION

The hypotheses for this study were partially supported. In support of the first hypothesis, both state shame and state guilt appeared to be high in the study's population. Participants reported much higher scores on the shame and guilt subscales than University student

populations within the U.S. (shame: 14.26 versus 6.7; guilt: 17.11 versus 7.39). Assuming this measure has construct validity in this specific cultural context, these scores reflect a high prevalence of painful, self-conscious emotions, with scores in a range similar to populations seeking mental health treatment within the U.S. For example, shame and guilt scores in this sample are similar to those of male survivors of sexual abuse attending a support group in the United States (shame: 17.42; guilt: 9.43) (Dorahy & Clearwater, 2012). Similarly, women beginning Dialectical Behavior Therapy for Borderline Personality Disorder scored an average of 14.5 on the shame subscale (Rizvi & Linehan, 2005). Findings are similar to previous research that found high levels of guilt and shame in the SSGS specifically in individuals diagnosed with HIV and/or people living with HIV/AIDS (Cantisano, Rime, & Munoz Sastre, 2015). High levels of guilt have also been found in women with histories of interpersonal violence (Kubany, 1994, 1995). Given that 80% of the participants in this study reported a history of interpersonal violence, this is especially relevant.

Understanding reported shame and guilt is important for many reasons, including developing future interventions for HIV positive women in India and elsewhere. For example, research indicates that in other Asian populations, high levels of shame following stressful events have predicted the development of PTSD (Uji, Shikai, Shono & Kitamura, 2007). High levels of guilt and shame can affect all stages of psychological intervention and treatment such as help seeking behaviors, diagnosis, treatment, recovery and relapse (Kubany & Watson, 2003). High levels of HIV/AIDS related shame have also been shown to negatively affect medication adherence, be correlated with risky sexual behavior and lead to a reduced quality of life. Focusing on addressing shame in a therapeutic setting may increase the potential for recovery, especially if the shame is HIV related (Konkle-Parker, 2008; Persons, 2008; Neufeld, 2012). It

is important to understand more about how shame may function in high context cultures because the experience and consequence on mental and physical health could differ from one culture to another. While the unique ways in which shame and guilt are experienced by women living with HIV and AIDS in India has yet to be fully understood, the findings from this study help to paint a more accurate picture of the experience of one group of Indian women living with HIV.

Shame and guilt can have implications for mental health and wellbeing. Findings from this study support the second hypothesis, higher state guilt was significantly correlated with higher depressive and PTSD symptoms. In contrast, state shame was not significantly correlated with mental health symptoms measures in this study. Previous research has indicated that guilt is associated with poorer mental health in people living with HIV/AIDS (Cantisano, Rime, & Munoz Sastre, 2015). PTSD and depression have both been associated with guilt in previous research (Beck et. al., 2011; Kim, Thibodeau, & Jorgensen, 2011; Beck et. al., 2011; O'Connor, Berry, & Weiss, 1999).

A lack of correlation between state shame and depressive symptoms and PTSD differs from widely published literature reporting associations between shame and PTSD (Lawrence, & Taft, 2013; Tangney & Dearing, 2002; Lewis, 1971). Null results may be due to many factors including - limited statistical power due to the small sample size, difficulty with construct validity or other aspects of the measures, or cultural differences in the experience of self-conscious emotions.

While the core team of researchers attempted to adhere to best practice guidelines for adaptation of measures cross-culturally, they experienced various constraints that may have negatively impacting construct validity. For example, there was insufficient time to rigorously norm and validate measures for use with this specific population. Some more abstract constructs

such as guilt and shame may not have been effectively communicated in Tamil. Although fairly rigorous translation and back translations procedures were followed, time did not allow for adherence to the additional steps recommended by Borsa, Damásio, & Bandeira (2012), including evaluation of the translated measures by expert judges, instrument evaluation by the target population, and a full pilot study. Poorly translated instruments threaten validity (Wild et al., 2005).

Although the SSGS is a measure of state shame and guilt, previous research examining the five-month stability coefficients (.53 for the guilt scale and .57 for the shame scale) indicate these are nearly as large as those for a much lengthier guilt-proneness and shame proneness measures, such as the TOSCA-A (.58 and .64, respectively) (Tilghman-Osborne, Cole, Felton & Ciesla, 2008). This suggests there may be some inherent limitations of the measure's ability to differentiate state shame and state guilt from proneness to feeling shame and guilt. As a result, data in this study may be reflecting more stable trait guilt and trait shame.

## CONCLUSION

This study provides evidence of high levels of guilt and shame in a sample of HIV-positive women in southern India. Findings also suggest that such self-conscious emotions may have implications for mental health and wellbeing. Future research should focus on more rigorous approaches to adapting measures of shame and guilt to a specific cultural context, especially considering the potential clinical utility of developing a better understanding of these constructs.

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