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AN INVESTIGATION OF STIGMA AND SHAME IN HIV AND HOMOSEXUALITY: AN AFFECT THEORY AND SHAME THEORY PERSPECTIVE

By

Joshua Marcus Cohen

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ABSTRACT

AN INVESTIGATION OF STIGMA AND SHAME IN HIV AND HOMOSEXUALITY: AN AFFECT THEORY AND SHAME THEORY PERSPECTIVE

By

Joshua Marcus Cohen

Through the lens of Affect Theory and Shame Theory, this study evaluated the affective reactions of college men when confronted with issues related to HIV infection and homosexuality. In the study, 131 subjects completed a Demographic Questionnaire, a Sexual Orientation Questionnaire, and a Health Status Questionnaire. Next, each subject completed an Internalized Shame Scale (ISS) used to rate their own level of internalized shame. Then each subject read one of four vignettes. The vignettes described a male college student who is either HIV+ and Homosexual, HIV+ and Heterosexual, has Leukemia and is Homosexual, or has Leukemia and is Heterosexual. Next, subjects completed a second Internalized Shame Scale, this time answering questions to describe how the man in the vignette feels; this yielded projected-shame ratings. They also completed an Affect Inventory, again describing their projected feelings for the man in the vignette. Finally, each subject wrote a short paragraph about their responses. Two hypotheses were tested: Hypothesis One predicted a 3-Way Interaction between Disease, Sexual Orientation, and ISS-scores, the Target of shame ratings Factor. Moreover, it was predicted that the following rank order of responses would be produced: the largest increase in shame scores between the ISS-self score and the ISS-projected score would be

generated for the vignette describing HIV+ status and Homosexuality; the second largest increase would be generated for the vignette describing HIV+ status and Heterosexuality; the third largest increase would be generated for the vignette describing Leukemia and Homosexuality; and the smallest increase would be generated for the vignette describing Leukemia and Heterosexuality. The 3-Way Interaction was not significant, although the results did reveal a significant Main Effect for Disease. Hypothesis Two predicted an Interaction Effect on the Affect Inventory for Disease and Sexual Orientation. Here, it was predicted that the highest scores would be generated on the "shame" sub-scale of the Affect Inventory for vignettes describing HIV+ status and Homosexuality; second highest for HIV+ status and Heterosexuality; third highest for Leukemia and Homosexuality; and the lowest for Leukemia and Heterosexuality. In order to test Hypothesis Two, a Repeated Measure ANOVA and a MANOVA were computed. The 2-Way Interaction was not significant. The Affect Inventory was also analyzed using a Principal Components Analysis, followed by an Exploratory Factor Analysis of the Principal Components solution. The results revealed two factors and, overall, the Affect Inventory was found to have statistically sound construction. The discussion explored the Affect Inventory's construction, possible reasons for the non-significant and significant findings, ideas for future research in this area, and the clinical implications of this research.

First, I dedicate my dissertation to my wife, Sandy Cohen.
Sandy has been my source of strength throughout graduate school,
providing the love, support, and encouragement I needed for survival.
She is the finest person I know, the love of my life, and the ultimate partner.

Second, I dedicate my dissertation to the participants of the "Men's HIV+ Support Group"of East Lansing, Michigan. Between 1996 and 1999, those men invited me to share their experiences and allowed me to enter their lives and learn.
All of them will live in my heart and my memory forever.

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Dissertation Committee, Dr. Kaufman has been my mentor in almost all aspects of my training. Always available with a warm hug and positive encouragement, but never avoiding the opportunity to guide with necessary constructive criticism, Dr. Kaufman is the ultimate mentor. Without his guidance and support I would not have completed my degree and would have missed the chance to continue doing therapy, my life's dream. With all my love and admiration, thank you Gersh.

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CHAPTER 1
STATEMENT OF THE PROBLEM

In 1979, the signs of a disturbing medical phenomenon were first identified in medical settings in the United States (Curran, 1983).

> An unidentified disease mysteriously focuses on one group. This group, of which you are a member, is a minority.
>
> Your friends are becoming ill and dying ugly and painful deaths. Even the ringing of the telephone is no longer a friendly sound: it may bring yet more painful news. You watch yourself daily for symptoms. People in the general population are becoming frightened of catching the disease from you. The government shows curious lethargy in response to what has, in two years, become one of medical history's most enigmatic major epidemics. There is talk of quarantine.
>
> The disease has an incubation period that can be as long as three years, and large numbers of your group may already have contracted the dreaded disease without knowing it. Even the most healthy-looking people may be capable of transmitting the mysterious agent. Everyone is terrified. (Morin, Charles, & Maylon, 1984)

Batchelor (1984, p. 1279) argued early on that "the mention of AIDS causes people to draw back in fear; it has the emotional impact of a modern-day plague. AIDS has become a psychological emergency" leading Odets to conclude that although "widely perceived as an important medical issue, the AIDS epidemic is also a mental health catastrophe perhaps unmatched in 20th century American history" (1995, p.1).

By 1981, the first deaths associated with that phenomenon – now known as two separate but usually co-morbid diseases, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) were identified and publicly reported by the Centers for Disease Control and Prevention (CDC) (Batchelor, 1984; Nicholas, 1983). While research into the physical and medical aspects of these diseases became popular, there had been much less research on the psychological impact of HIV and AIDS.

In part, the need for further evaluation of the psychological ramifications of an HIV-positive/AIDS diagnosis is evident from the fact that research conducted in this area has yielded conflicting results. Some reports suggest that the impact of an HIV-positive (HIV+) diagnosis involves tremendous stress and turmoil that can lead to significant psychological problems. Other studies, however, found statistically non-significant results emerge from comparing psychological profiles of people who are HIV+, and HIV-negative (HIV-). Still other researchers have reported that, while important psychological issues do arise, the progression of the illness accounts for most of the timing and severity of those issues. Since the progression of HIV/AIDS does not follow any single consistent path, one is left unsure about how and when to prepare for the associated psychological difficulties. Effective coping requires an understanding of the psychological issues that a person with AIDS will likely confront. These include, but are not limited to, reactions engendered by societal attitudes toward people with AIDS along with the related feelings of shame that are hypothesized to accompany an HIV+ diagnosis.

The shame about HIV and AIDS parallels the shame associated with homosexuality. Kaufman's (1996) theory of shame and culture argues that all cultures have their particular targets of shame. In American culture, sexual acts between individuals of the same sex have become a primary target of shame. Homosexual behaviors have been labeled as dirty, unnatural, against G-d's intentions, inferior, etc. Likewise, society has deemed people who engage in such acts as dirty, unnatural, inferior, and as people who will suffer G-d's wrath because they have gone against His will. Furthermore, homosexual behavior has been so strongly shamed that homosexuals have been viewed as not being human at all, leading some people to physically harm and kill

them.

Society's message about homosexuality influences both society's collective self-concept, defining its character, and the self-concept of the individuals who make up that society. To the individual who experiences desire for same-sex affection, these messages are personally shaming and the *script* that develops for that individual often becomes one which is shame-based; the homosexual explains his own feelings and thus himself as fundamentally bad, inferior, dirty, unnatural, etc.

The present study aimed to investigate the relationship between societal stigmatization, shame and HIV/AIDS, and also the relationship between stigmatization, shame, and homosexuality. Tomkins's (1962, 1963, 1991, 1992) Affect Theory and Kaufman's Shame Theory (1992, 1996) served as the theoretical foundations for this study. The current literature reports inconsistent results regarding the amount of psychological distress found in HIV+ individuals compared to HIV- individuals. While HIV+ status does likely result in increased levels of psychological disturbance, which is often reported to include such global diagnoses as depression, anxiety, or adjustment disorder (Brauer, 1994; Morin & Batchelor, 1984; Morin, Charles, & Maylon, 1984), this connection is likely to be mediated by various processes. One such process is hypothesized to be shame. This study aims to clarify the stigmatization process along with the role of shame in both HIV illness and homosexuality by examining how a normal healthy population projects its own affective reactions onto fictitious people. Utilizing a "projective" measure of shame will hopefully reveal the affective reactions generated by HIV/AIDS and also by homosexuality.

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Stigma and Shame: The Nature of Societal Attitudes Toward HIV/AIDS and Homosexuality

Substantial research already shows that a variety of people in completely different circumstances can share a common disdain for people who are either HIV+ or homosexual. St. Lawrence, Husfeldt, Kelly, Hood, and Smith (1990) found that college students had highly negative and almost interchangeable prejudices toward people with AIDS and gay men. Other research teams have reported that people with negative attitudes toward homosexual men also show higher levels of stigmatization toward People with AIDS (Lennon & McDevitt, 1987 cited in St. Lawrence et al., 1990; O'Donnell et al., 1987). Similarly, physicians, medical students, and nurses, in locations with low numbers of People with AIDS, comparing two patients with the same descriptions except for type of illness, have been found to rate people with AIDS as less deserving of medical treatment, more responsible for their illness, less of a loss to the world if they died compared to other patients, and more deserving of quarantine than others (Crandall, 1991; Katz, Hass, Parisi, Astone, Wackenhut, & Gray, 1987; Kelly, St. Lawrence, Hood, Smith, & Cook, 1987a; Kelly, St. Lawrence, Hood, Smith, & Cook, 1987b; Kelly, St. Lawrence, Smith, Hood, & Cook, 1988; St. Lawrence, Kelly, Owen, Anthony, Indira, 1990). These data suggest that even people who are presumed to be well educated regarding HIV/AIDS are still prone to unfounded prejudice. Fortunately, because the people in this data sample had little contact with HIV+/AIDS patients, they may not have had the opportunity to directly impart to patients their prejudicial views. Such good fortune, however, will likely not last since it is becoming clearer that the AIDS epidemic is no longer a problem limited to large metropolitan epicenters. As the epidemic continues to spread out from cities to

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smaller rural towns in the United States, there will be an increased need for psychologists [and others] to be able to help people with AIDS. However, when St. Lawrence et al., (1990) examined the attitudes of 126 psychologists toward AIDS, the researchers found that AIDS patients were perceived more negatively than others, and that participating psychologists reported less willingness to interact with the AIDS patients either in a professional role or in a casual social situation. In their research design, each participant was asked to read one of four vignettes, which were identical in all respects except that the subjects portrayed in the different vignettes were either homosexual or heterosexual, and had either AIDS or Leukemia. Participating psychologists rated the vignette subjects on three measures. First, the Prejudicial Evaluation Scale, a 12-item scale constructed to assess health providers' attitudes toward AIDS (Kelly, St. Lawrence, Hood, & Cook, 1987a). In this study, respondents rated each item on a 7-point Likert scale (e.g., ratings from 1 = disagree to 7 = agree). Second, the Social Interaction Scale (SIS) includes descriptions of seven casual social interactions that could take place with the person described in the vignette. These were used to examine the subject's willingness to interact with the portrayed patient. An additional item evaluated the subject's willingness to treat the portrayed person in his/her clinical practice. Like the Prejudicial Evaluation Scale, these items were also ranked on a 7-point Likert scale ranging from one to seven. The third measure used in this study was the Interpersonal Evaluation Inventory (IEI). The IEI is an assessment tool sensitive to social evaluation and likeability. The IEI is made up of 24 adjectives (e.g., warm, appropriate, truthful, kind, etc.) each of which is rated on a 7-point Likert scale (e.g., 1 = extremely open-minded to 7 = extremely close-minded) with scoring direction counterbalanced to control for response set bias.

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As previously stated, St. Lawrence, et al., (1990) found that AIDS patients were perceived more negatively than others, and that participating psychologists reported less willingness to interact with the AIDS patients either in a professional role or in a casual social situation. Interestingly, no significant differences were found between homosexual and heterosexual variables.

As St. Lawrence, et al., (1990) report, the psychologists' responses reveal their underlying attitudes and also demonstrate similarities between psychologists in the sample and the lay public:

> Psychologists rated the AIDS patient as more responsible for his illness, experiencing more pain and suffering, more dangerous to others, deserving of the best medical care possible, a person for whom suicide is more likely to be the best solution, and who is more deserving of quarantine. (1990, p. 360)

These data suggest that irrational fears may prevent psychologists from helping people who may desire and require services, an unfortunate outcome for the profession of clinical psychology. In fact, People with AIDS who receive services from a psychologist are prone to have a negative experience due to the therapists' biases, an experience also reported by many homosexual men (Baron, 1996; Cornett, 1993; Fassinger, 1991; Martin, 1982; Morin & Rothblum, 1991). Conceivably, if the negative therapy encounter left the client unwilling to attempt another therapy experience, and prevalence of therapy for AIDS patients' depends on reported therapy contacts, then this could account for the reported decrease in psychopathology found among People with AIDS (Atkinson et al., 1988).

Research on HIV/AIDS and Homosexuality: The Role of Stigma

Psychological issues vitally important to our understanding and treatment of People with HIV/AIDS have remained under represented in recent research efforts. This is striking since having an awareness of psychological issues has been recognized by experts as fundamental to our complete understanding of HIV/AIDS. To some researchers the severe psychological impact of HIV/AIDS appears obvious (Brauer, 1994; Morin & Batchelor, 1984; Morin, Charles & Maylon, 1984), while others report findings which suggest less severe psychological problems. Although it is easy to see how psychological distress embedded in one's response to societal reactions to HIV/AIDS would reasonably be expected to impact people who are afflicted with HIV/AIDS, the remaining confusion may be partly due to the lack of understanding about not only the experiences of people who are either HIV+ or homosexual, but also the experience of people who stigmatize these groups. Therefore, attention must be given to understanding the process of stigmatization itself.

In recent years, researchers have begun to consider the impact of stigmatization (Baron, 1996; Chesney & Folkman, 1994; Herek & Glunt, 1988; Le Poire, Hiroshi, & Hajek, (1997). However, the pioneering work by Irving Goffman (1963) is still considered the cornerstone of understanding stigmatization. Goffman was the first researcher to describe the *process of stigmatization* and his conceptualization of that process, originally presented in Stigma: Notes on the Management of Spoiled Identity (1963), has remained the primary treatise on this subject for more than 30 years.

Goffman defines stigma as an attribute or blemish of either physical characteristics (e.g., a handicap, deformity), of character (e.g., mental disorder, untrustworthy), or of

tribal association (e.g., race, religion). He further defines the process of stigmatization as taking place when one's expectations of a person or group are changed by an awareness of an "attribute or blemish" that is deemed abnormal and unexpected. This awareness creates a conflict between the previous assumption of "normalcy" about the person or group and the sudden awareness of an intrusion of the "abnormal." When that occurs the person with a blemish indeed has become stigmatized, excluded from the group called "normals."

Using Goffman's conceptualization, people who are HIV+ could be placed into the stigmatized categories of physical handicaps due to illness and also of character due to mental disorder (e.g., dementia). Likewise, homosexuals could be placed into the stigmatized categories of having either a character blemish or one of tribal association.

There are many instances found in everyday life which would support Goffman's formulation. Examples of stigmatization and discrimination suffered by People with AIDS are well known to the general public through a bevy of popular articles reporting on the traumatizing experiences and psychological stressors faced by them. Ship wrote that "a Massachusetts teacher was ordered to take a medical leave and then to resign when rumors circulated that he was being treated for AIDS. After demonstrating to school officials that his medical problems were associated with a blood disorder not related to AIDS, he was allowed to return to teaching. Threatening phone calls and harassment continued, however, and he felt compelled to take a leave of absence" (The New York Times, 1986, p. 8). William F. Buckley Jr. argued in 1986 that "everyone detected with AIDS should be tattooed in the upper forearm, to protect common-needle users, and on the buttocks, to prevent the victimization of other homosexuals" (The New York Times,

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p. A 27), an approach reminiscent of Nazi Germany. And Robinson (1987), writing for the Boston Globe, reported that in "Arcadia, Florida, three brothers tested positive for Human Immunodeficiency Virus (HIV). After word spread of their infection, their barber refused to cut the boys' hair, and the family's minister suggested they stay away from Sunday church services. Eventually, the family's house was burned down" (p.1).

In these examples, society identified these individuals as belonging to a different category than normal. Society also treated them differently than they would treat someone considered "normal." That is the process of stigmatization.

Moreover, the events characterized above were traumatic. It would be difficult for anyone to suggest that such encounters, experienced either personally or vicariously via identification, would not have a powerful adverse impact on psychological health. Based on the accumulated evidence, some researchers believe that increased levels of affective disorders, adjustment disorders, stress, and even suicide have now been widely observed among people diagnosed as HIV+ or having AIDS.

Persons with HIV/AIDS are also likely to be stigmatized on other grounds beyond those directly related to HIV/AIDS. This additional stigma has been directed at homosexuals and intravenous drug users (IVDU) and predates HIV/AIDS (Brauer, 1994; Bennet, 1987; Crandall, Glor, & Britt, 1997; DeMarco, 1998; Herek & Glunt, 1988, 1991; Kaufman, 1996; Kaufman & Raphael, 1996; Limandri, 1989; Morin, Charles, Maylon, 1984; Morin & Rothblum; 1991). Homosexuals and IVDU have long been considered deviant and have been categorized as separate and different by people who have been too uncomfortable to tolerate these differences. Chronic grief/loss issues and fear of public disclosure about sexual orientation and/or drug use are also concerns

experienced by People with AIDS and would also be expected to impact both their lives and daily activities (Altman, 1986; Bennet, 1987; Crandall & Coleman, 1991; Elford, 1987). Herek and Glunt (1988) reported that comprehending the "AIDS Epidemic in the United States requires an understanding of the phenomenon of widespread, intensely negative reactions to HIV-infected persons. These negative reactions have shaped the behavior of infected individuals and have limited the effectiveness of prevention efforts" (p. 886).

In addition to fear about the reactions from the general public, there is reason for these people to fear reactions from those who should be in a position to help them. After all, members of the mental health profession have participated in the stigmatization process. In the case of stigmatizing homosexuality, it is important to note that until 1973, homosexuality was listed in the Diagnostic and Statistical Manual, Third Edition Revised as a mental illness (Morin & Rothblum, 1991), placing homosexuality in the "blemish of character" category described by Goffman. This classification has allowed the mental health profession to view homosexuals as separate and different from "normal people," establishing an "us and them" approach to diagnosis and therapy. The mental health profession's stigmatizing practices have often created iatrogenic wounds while simultaneously denying these populations the basic services available to others.

There are other psychological difficulties specific to HIV/AIDS, which therefore have a selective impact on homosexuals and IVDU, namely grief and loss issues and the effects of stress on the immune system.

Grief and Loss Issues

Grief and loss are generally experienced whenever people die, and death is certainly a primary issue for people who are afflicted with HIV/AIDS. The HIV+ person must deal not only with issues related to his/her own mortality, but with the loss of many friends and loved ones as well. Tremendous numbers of losses are common in areas with large numbers of People with HIV/AIDS. For example, considering New York and California, these two locations combined to account for 56% of the national total number of AIDS cases in the United States in 1986. Assuming that the death rate in both New York and California was similar to the death rate in Michigan, then between 1981 and 1986 approximately 5020 people died of AIDS within six years of diagnosis (Michigan Department of Public Health Acquired Immune Deficiency Syndrome Statistics, 1986). This represents large numbers of people who have grieved the losses of loved ones, many of whom were likely to have been HIV+ or AIDS infected themselves.

Equally as devastating can be grief over losses that are not specifically death-related: loss of job due to poor health, loss of income, loss of lifestyle and socioeconomic status, loss of family and friends who now discriminate, loss of religious support, loss of physical/bodily control, loss of physical appearance do to illness, loss of freedom to travel (either by government sanctions against people with HIV+/AIDS leaving and entering the country or due to the necessity to be close to one's doctor and pharmacist), and loss of sexual contact due to fear of contaminating another (Lopez & Getzel, 1984; Morin, Charles, Maylon, 1984; O'Rourke & Sutherland, 1994; Ruhala & Woodring, 1993). This list only scratches the surface of the many losses suffered by HIV/AIDS infected people. Such losses would undoubtedly be characterized as stressful and problematic in anyone's

life. However, because they are multiple and cumulative, the effects of stress are *more significant* to the person who is HIV+/AIDS than to other people.

Psychoimmunology. The many losses experienced by persons at risk for infection by HIV put additional stress directly on the immune system. Psychoimmunology is the study of the immune system's reactions to stress and other significant life events. The evidence now clearly demonstrates that psychological issues such as distress, bereavement, disruption in personal relationships, and transitional life events have a significant effect on the immune system (Bloom, Asher, & White, 1978; Cohen & Syme, 1985; Kiecolt-Glaser & Glaser, 1988; Renne, 1971; Verbrugge, 1979). The biological process implicated here, though complex, has been documented.

There are multiple biological processes which combine to influence the immune system, suggesting that one area of immune system functioning affects other areas of immune system function. For example, the endocrine system, which has been shown to be responsive to different emotional states and levels of stress (Baum, Grunberg, Singer, 1982), has also been found to have considerable effect on the number of t-cells (a central component of the immune system) in the blood. Epidemiological studies have found support for the idea that emotional states and interpersonal relationships have health-related consequences: changes in emotional states and levels of stress have a weakening effect on immune system functioning. For example, Cohen and Syme (1985) found greater morbidity and mortality in people who have fewer close relationships. Bloom, Asher, and White (1971) showed that both the quality of relationships and disruption of relationships are important determinants of physical health. Likewise, studies looking at physical health following marital separation and/or divorce have shown higher rates of

infectious disease and cancer (Ernster, Sacks, Selvin, & Petrakis, 1979; Somers, 1979) following disconnection from one's spouse. Similarly, data from bereavement studies show that men who have wives dying of breast cancer also have poorer lymphocyte proliferation (development of immune system blood cells) following their spouse's death than before (Schleifer, Keller, Camerino, Thornton, & Stein, 1983). Also, in recently bereaved women, there is lower natural killer cell activity (immune system blood cells) than in age-matched non-bereaved women (Irwin, Daniels, Smith, Bloom, & Weiner, 1987).

These findings are particularly important for People with HIV/AIDS. Those communities which have been most affected by AIDS, such as the homosexual and IVDU communities, have encountered large numbers of losses and have grieved the deaths of countless people who have fallen to AIDS. These same communities have experienced significant amounts of stress due to stigmatization, discrimination, and poor health. It must be recognized that many of the people living in these communities who are grieving losses are also HIV+/AIDS patients. In fact, in many instances entire families are HIV+/AIDS patients. This results from the sexual transmission of the virus and subsequent transmission from mother to an unborn fetus (Sherr, 1995).

Finally, repeated stress or grieving does not appear to be something that the body and immune system readily adjust to. This has been shown in a series of studies by Glaser, Rice, Speicher, Stout, and Kiecolt-Glaser (1986) using medical students as subjects. Blood samples one month prior to medical school exams (low stress period) were compared to blood samples taken during examinations (high stress period). The results showed that blood samples taken during periods of high stress had lower levels of immune

system cellular activity (i.e., the presence of natural killer cells) compared to low stress periods. This suggested poor immune system functioning during stressful times. Moreover, in spite of these students' long history of successful exam-taking behavior, which is implied by having achieved medical school entrance status, repeated instances of stress do not appear to help one's body react more efficiently to future stress.

In summary, grieving for friends and loved ones who have died of AIDS, along with other life stressors including those associated with stigmatization, all contribute to a general weakening of the immune system. For HIV+/AIDS patients, these stressful events negatively impact an already compromised immune system. This data alone highlights the need to more effectively confront the psychological issues encountered by the HIV+/AIDS communities.

Studies of HIV/AIDS and Psychological Disorders: Methodological Problems and Conflicting Findings Signify the Need for a New Research Paradigm

One source of information regarding the psychological impact of AIDS is research evaluating the connection between HIV/AIDS and depression/anxiety, suicidal behavior, and adjustment disorders. While certain research reports reveal statistically significant differences in psychological health between HIV+ and HIV- people, other studies report no significant differences.

Significant Research Findings

Researchers studying the psychological dimensions of HIV/AIDS have commonly used subjects from high-risk groups, primarily consisting of intravenous drug users (Hestad, Aukrust, Ellersten, & Klove, 1994; Lipsitz, et al., 1994; Pakesch et al., 1992) and men who have sex with men either exclusively or in addition to women (Atkinson, Grant, Kennedy, Richman, Spector, & McCutchan, 1988; Bungener, et al., 1993; Catalan et al., 1992; Chuang, Jason, Pajurkova, & Gill, 1992; Ostrow et al., 1989), so that the psychological ramifications of being a drug user or homosexual are confounded with those specifically related to AIDS. Within these groups, researchers have focused on three main areas of psychological disturbance: 1) affective disorders including depression and anxiety (Atkinson, Grant, Kennedy, Richman, Spector, & McCutchan, 1988; Cazzullo, Folkman, Chesney, Pollack, & Coates, 1993; Ostrow, Joseph, Kessler, Soucy, Tal, Eller, Chmiel, & Phair, 1983; Ostrow, Monjan, Joseph, VanRaden, Fox, Kingsley, Dudley, & Phair, 1989); 2) adjustment disorders (Bungener, Kosmadakis, Jouvent, & Widlocher, 1993; Lipsitz, Williams, Rabkin, Remien, Bradbury, Sadr, Goetz, Sorrell, & Gorman, 1994); and 3) rates

of suicide (Gala, Pergami, Catalan, & Riccio, 1992; McKegney & O'Dowd, 1992; Rajs & Fugelstad, 1992).

In an early report, Atkinson, et al., (1988) studied depression and anxiety in five subject groups: 1) homosexual men given an AIDS diagnosis using the CDC criteria; 2) homosexual men given a diagnosis of AIDS Related Complex (ARC) using the CDC/NIH criteria; 3) homosexual men diagnosed HIV+ but not diagnosed with AIDS or ARC; 4) homosexual men who were HIV-; and 5) heterosexual men who were considered healthy. These researchers investigated the prevalence of psychiatric/psychological disorders in gay male subjects with AIDS in order to evaluate whether the common reports of increased rates of depression and anxiety were a product of a subject selection artifact. In addressing this question, the research team investigated psychological problems in terms of lifetime prevalence, six-month prevalence, and the onset of problems in relation to a diagnosis of AIDS or ARC. The psychological status of gay men who were HIV+ was also compared to that of gay men who were HIV- and to heterosexual men who were healthy. All groups were evaluated for the pre-morbid prevalence of psychiatric illness.

Their results indicated that the groups of homosexual men had a high rate of lifetime prevalence of diagnosable psychological illness. Although the majority of the homosexual men developed diagnosable disorders of one type or another prior to becoming HIV+ or acquiring AIDS or ARC diagnoses, "only 4 of 17 (23.5%) noted the onset of generalized anxiety disorder at a time remote from the beginning of the AIDS epidemic" (Atkinson et al., 1988, p. 863). Additionally, the AIDS population in this study demonstrated higher rates of major depression for both lifetime (30.3%) and past-six month periods (10.7%) compared to the results of pooled data from the epidemiologic

catchment area reporting lifetime and current estimates of 5%, and 3%, respectively, for similarly aged men. The AIDS population in this study also surpassed the control group's rates of 10% and 0%, respectively, on these dimensions. Even though the results were not statistically significant, these researchers have observed an important psychological phenomenon.

What was found to be statistically significant were those differences between the HIV+ group of gay men compared to the control group of heterosexual HIV- men. Comparing the lifetime prevalence of psychiatric disorders, 88.2% of the gay HIV+ men had a diagnostic history of psychological disturbance compared to 59.1% of the heterosexual HIV- control group. However, that diagnostic history always predated the HIV+ diagnosis. While it is impossible to conclude that the psychopathology observed in this sample resulted from an HIV+ diagnosis (Atkinson et al., 1988), it may still have increased vulnerability to future episodes of diagnosable psychological problems, due to AIDS.

In another investigation of the psychological concomitants of AIDS, Johannet and Muskin (1990) gathered data from inpatient hospital charts and found that People with AIDS had higher rates of psychiatric consultations than any other group of inpatients. Similarly, O'Dowd and McKegney (1990) found that HIV+ patients and People with AIDS had more repeated contacts with the psychiatric staff compared to other inpatient groups. Finally, Sacks et al., (1995) reported that a small but a significant increase in the number of new psychiatric inpatients who may not have otherwise entered inpatient treatment appears to have been brought about by the AIDS epidemic.

The data presented above lead to the conclusion that a diagnosis of HIV or AIDS

creates such a high level of psychological distress that it drives people to seek professional assistance. These data must be interpreted cautiously, however, for two reasons. First, these subjects comprised a specialized group because they were all inpatients; thus, the results do not necessarily generalize to people who do not require inpatient psychiatric treatment. Second, people who are on an inpatient unit may already have a more serious condition than those who are not hospitalized. Conversely, if the more physically compromised person does choose to seek psychiatric consultation because of increased distress and pain, being at a more difficult time in life or being closer to death, then such action could instead be viewed as a sign of positive mental health in the form of disease acceptance and efforts toward self-empowerment, not psychological pathology.

In other research, O'Dowd, Natali, Orr, and McKegney (1991) reported on data gathered from charts of patients at an outpatient HIV psychiatric clinic which is affiliated with a large hospital in New York City. The hospital was responsible for 82% of the referrals while the remaining 18% of referrals came from outside sources. The questions being examined were: 1) Why did 50% of the referrals never attend their first appointment? 2) Why did 45% of the patients not return following a first appointment? 3) Were there demographic characteristics of the referred population which could be used to predict appointment keeping/appointment breaking behavior? Demographic variables taken from hospital charts were examined to evaluate possible differences between 100 patients who never attended their first appointment and 224 patients who completed the entire intake process ($\underline{N}$ = 324).

The results showed that of the 324 cases at least one Axis I diagnosis from DSM-III-R was given to 98% of the people; 44% had previous psychiatric treatment; 31% had a

history of psychiatric hospitalization; and 38% had a history of outpatient treatment. The most common diagnosis given at the time these hospital charts were created was adjustment disorder (65%), followed by substance abuse (44%), while only 12% were diagnosed with an affective disorder. The small percentage of affective disorders was unexpected, leading the authors to conclude that this finding may have been the consequence of under-reporting since they did not distinguish between subtypes of adjustment disorders, but instead found many individuals diagnosed with an adjustment disorder to also be depressed and anxious. The possibility remains that the subjects did not feel the need for mental health treatment, but the health professional making the referral determined that a referral was necessary.

Still, another factor may help explain the findings with regard to affective disorders. It is important to note that the current DSM-IV criteria for diagnosing affective disorders employs qualifying statements regarding substance abuse as an etiologic component of the affective disorder. Therefore, in the O'Dowd et al., (1991) study, elevated levels of substance abuse may well have limited accuracy when diagnosing affective disorders.

Conversely, O'Dowd et al., (1991) also found that patients who had a history of substance abuse and were currently involved in a methadone program were more likely to remain in the program compared to those who were not on methadone. Those people who received prescription medication at their first visit were also more like to stay connected to the program than those who did not receive a prescription. Finally, although not a significant difference, those people who were receiving AZT medication were more likely to continue with treatment than those who did not receive AZT medication. The

authors speculated that those "individuals who have been able to organize themselves sufficiently to use other programs – whether psychiatric clinics, methadone programs, or AZT clinics – are perhaps more likely to be able to continue in a new program" (O'Dowd, Natali, Orr, & McKegney, 1991, p. 618).

O'Dowd et al., (1991) gathered useful information in their attempt to understand the characteristics of the people served in their mental health clinic, especially given the unique presenting problem of these people. This study suggests that many people who have AIDS are seen by the medical community as needing psychiatric attention. It would have been more useful, however, to have comparison data for the general population's rate of "no-show and early dropout" behaviors for psychiatric appointments. The possibility exists that the number of people who do not show for an initial psychiatric appointment, or do not return for second psychiatric appointments are the same as in the data presented by O'Dowd et al., (1991), regardless of the population being served.

In another study (Lipsitz, Williams, Rabkin, & Remien, 1994), HIV+ and HIV-, male and female intravenous drug users were subjects for an evaluation of their levels of psychopathology. Using the Structured Clinical Interview along with measures of symptom severity, global functioning, and stress, the results obtained showed that the prevalence of a current diagnosis of depression and symptom severity for both depression and anxiety were higher among these subject groups than within the wider community. Although much of the depression was accounted for by the history of drug abuse, sub-samples of this population revealed depression which was strongly linked to HIV infection. For instance, relative to other drug users, HIV+ men demonstrated a higher prevalence of depressive disorder than HIV- men. The severity of both depressive and

anxiety symptoms were also related to the symptom-based measure of HIV (Lipsitz, Williams, Rabkin, & Remien, 1994).

In a five-year longitudinal study, Rosenberger et al., (1993) found that an HIV+ diagnosis does not precede, but can nevertheless contribute to, the acute presentation of psychiatric illness. The data suggest that a positive diagnosis of HIV infection did not cause psychiatric disorders in this sample, a finding consistent with other research. However, the stressful events which stem from HIV-related problems can serve as a catalyst for new episodes of anxiety, substance abuse, and adjustment difficulties.

More specifically, Rosenberger et al., (1993) studied 197 gay and bisexual men who were either HIV+ and asymptomatic since diagnosis (N = 102), HIV+ with symptoms (N = 64), or HIV- (N = 31). They were given psychological evaluations to determine both their current and lifetime psychiatric functioning. As in other studies considering lifetime prevalence of psychiatric disorders (e.g., Atkinson, et al., 1988; Williams, Rabkin, Remien, Gorman, Ehrhardt, 1991), Rosenberger et al., (1993) found elevated rates of the lifetime psychiatric disorders in 166 HIV+ subjects. There were no significant differences between asymptomatic and symptomatic groups. When the two HIV+ groups were pooled, 79% of those subjects diagnosed with Affective Disorders reported their first episode prior to diagnosis of HIV infection. More specifically, 73% of the sample with a history of Major Depression reported their first episode prior to their HIV diagnosis, while 98% of those subjects diagnosed with a history of substance abuse reported an initial depressive episode prior to their HIV diagnosis.

Less dramatic findings suggested that 38% of the subjects with a history of Anxiety Disorder and 33% with a history of Adjustment Disorder reported their first

episodes prior to their HIV+ diagnosis. However, 12% of the HIV-infected subjects with a history of Anxiety Disorder reported at least one episode precipitated by HIV-related events, often positive diagnosis of HIV status on initial hospitalization for HIV illness. One percent of subjects with a history of Substance Abuse and 33% of subjects with a history of Adjustment Disorder reported an episode of symptoms, but following HIV-related events (Rosenberger et al., 1993).

In summary, some studies provide evidence that HIV/AIDS are highly correlated with psychological problems which are significant enough to require either a diagnosis or professional attention (Atkins et al., 1998). Similarly, there is evidence suggesting that, compared to others on inpatient units, those who have AIDS also have the most frequent requests for psychiatric consultations (Johannet & Muskin, 1990; O'Dowd & McKegney, 1990). Finally, there are now studies which connect diagnoses of psychological disorders and HIV status (O'Dowd et al., 1991). As stated earlier, many of these studies are fraught with methodological problems which presumably have impacted their results. In many instances, the research methods used and choice of research subjects introduced confounding variables which contaminated the findings.

Non-Significant Research Findings

Many of the difficulties in interpreting the studies just reviewed involve sample demand characteristics, especially risk group characteristics. For example, some researchers with intravenous drug user samples have not yet found ways to understand the impact of the diagnosis without including confounding variables associated with drug use. These variables include illicit behavior (e.g., using illicit drugs, stealing, sexual exploitation for drugs) and common beliefs that drug addicts are not trustworthy. Furthermore, this

subculture has difficulty trusting the mainstream culture which raises questions about differences between those IVDU who cooperate with research programs compared to those who do not cooperate (Rugg, Hovell, Franzini, 1990). These confounding variables make an accurate interpretation of collected data nearly impossible.

For high risk groups, such as homosexuals and IVDU, a history of psychiatric disorders prior to HIV+ diagnosis also has been used to explain diagnoses subsequent to HIV. This raises the question whether a subsequent diagnosis is the result of a person receiving an HIV+ status or the result of a natural progression of depression/anxiety, adjustment disorder, and the like (Atkinson et al., 1988; Johannet & Muskin, 1990; O'Dowd & McKegney, 1990; Rosenberger et al., 1993). The possibility exists that an HIV+ diagnosis would be dealt with differently by a person with a history of mental health problems than by a person without such a history.

Another explanation for inconsistent findings regarding a connection between HIV status and psychiatric illness is that non-significant findings, especially those found in studies of affect disorders, stem from faulty hypotheses generated by researchers. As Chesney and Folkman (1994) suggest, one reason for the continued focus on depression/anxiety, suicide, and adjustment disorders, particularly given a decline in the number of significant results, is that during the early years of the HIV epidemic a positive diagnosis of HIV infection was indeed associated with depression/anxiety, somatic complaints, and suicidal ideation (Jacobsen, Perry, & Hirsch, 1990; Ostrwo, Joseph, Kessler, 1989).

Chesney and Folkman further suggest that research which linked HIV+ status to psychiatric problems in general did have validity at one time, but may no longer be valid.

These researchers argue that "the evidence of adverse psychological effects of HIV infection diminished after 1988 despite the growing numbers of infected individuals and the spread of the epidemic outside the primary risk groups of gay and bisexual men, injection drug users, and individuals from Haiti" (Chesney & Folkman, 1994, p. 164). This research team attributes the diminishing significant results (and thus diminished negative psychological experience) to better pre- and post-test counseling along with an increase in the number of effective treatments that can offer a higher quality of life. For example, research results collected in 1985 revealed a high rate of suicide among people diagnosed with AIDS (Kizer, Green, Perkins, et al., 1988; Marzuk, Tierney, Tardiff, et al., 1988), whereas by 1993, Rabkin, Remien, Katoff and Williams (1993), reported an absence of suicidal ideation in gay men living with AIDS for at least three years. Likewise, Schneider, Taylor, Hammen, et al., (1991) reported that a cohort of asymptomatic HIV+ gay men had levels of suicidal ideation similar to that in an HIV- comparison group.

Chesney and Folkman's (1994) interpretations of the reports, suggesting a decline in significant amounts of psychiatric problems related to HIV status has merit, but also raises additional questions. Considering Chesney and Folkman's conclusion that negative psychological effects of HIV infection decreased after 1988 in spite of the increasing numbers of infected individuals and the new awareness of the virus in people outside the primary risk groups of homosexual and bisexual men, IVDU, and individuals from Haiti" (Chesney & Folkman, 1994, p. 164), why would one predict decreased psychopathology instead of increased psychopathology? Chesney and Folkman's supposition is in conflict with theories that speak strongly to the stigmatization which has followed groups that are

viewed as different, such as homosexuals and IVDU, and that have been attached to the HIV+/AIDS populations as well. It would seem more likely to conclude that an expanding population of people deemed "high-risk" should, in turn, increase the amount of psychopathology, not diminish it.

In summary, the results of these studies taken together have been equivocal. Some show psychological distress to be greater in people who are HIV+ compared to those who are HIV- (Johannet & Muskin, 1990; Belkin, Fleishman, Stein, Piette, & Mor, 1992; Bungener, Kosmadakis, Jouvent, & Widlocher, 1993; Fleishman & Fogel, 1994; Hayes, Turner, & Coates, 1992; Sacks, Burton, Dermatis, Looser-Ott, & Perry, 1995). Others, however, suggest that differences are less obvious if in fact they even exist at all (Atkinson et al., 1988; Lipsitz, Williams, Rabkin, & Remien, 1994; O'Dowd, Natali, Orr, & McKegney, 1991; Rosenberger et al., 1993). These accumulating results have forced researchers to reevaluate the accuracy of the heretofore "common sense assumption" that an HIV or AIDS diagnosis produces psychological disruption.

One way to reconcile these inconsistent results is by realizing that researchers have continued to expect the signs of mental health disturbance to take the particular form of depression/anxiety, suicidal behavior, and/or adjustment disorders as defined by the DSM criteria. While there certainly may be memories of times filled with depression/anxiety, suicidal ideation, and adjustment difficulties, continuing to look for only these specific problems is not the soundest research strategy. Such gross symptomotology as defined by the DSM may not, at the end of the 1990s, resonate as the primary issues for people who are HIV+ or for People with AIDS.

An alternative approach to the study of psychopathology related to HIV infection

is likely to yield more definitive results. Instead of focusing on symptom patterns that may or may not coalesce to form a depressive disorder, the present study aimed to articulate a different paradigm. This paradigm focused on society's affective reactions toward both AIDS and homosexuals along with the impact of societal reactions directly on People with AIDS and on homosexuals. It is precisely here that Goffman's early work on the process of stigmatization reasserts itself. Studying society's reactions to its outcasts means studying stigma and how it arises in social groups. But Goffman's thesis lacked one vital component: awareness of affect. He lacked both an understanding of affect and a language for accurately partitioning affect. Any research on stigmas must focus directly on affect. The research paradigm utilized in this study is informed by Affect Theory and Shame Theory, each of which is grounded in coherent psychological theory.

Affect Theory and Shame Theory:

Early Formulations and Later Theories of Shame

Shame has not received extensive attention in the psychological literature until relatively recently. While Freud certainly touched on shame (Freud, 1930, 1933), more attention was focused on guilt (Kaufman, 1996) whereas Adler, in contrast to Freud, paid much more attention to the effects of shame. The focus on inferiority feelings and the concept of inferiority complex (1933) are examples of Adler's increased awareness of the significance of shame-related phenomena (Kaufman, 1996). Conceptually, Adler's "inferiority complex" represents an early attempt to include shame as a key dynamic in the development of personality. Nevertheless, although "Adler seemed to perceive the effects of shame, he lacked an affect theory and a sufficient language to partition and rearrange the perceived data" (Kaufman, 1996, p. 8).

In another example of early psychoanalytic perspectives on shame, Karen Horney's theory of safety and satisfaction is suggestive of the *interpersonal bridge* concept of shame theory described by Kaufman (1996). In Horney's theory of development, for example, parents can undermine a child's sense of safety and security by acting in a variety of damaging ways. These include an obvious preference for one sibling over another, unkept promises, ridicule, humiliation, and isolation of the child from others (Schultz, 1986). Although Horney does not speak of shame per se, she describes situations and feelings which have more recently been included under the rubric of shame. Thus, where Horney employs examples of parental preference for another sibling, Kaufman refers to feeling inadequate or lesser; where Horney describes broken promises, Kaufman specifies disappointment and feeling unworthy of parental interest. Moreover, ridicule and humiliation a la Horney result in feeling exposed or *seen* a la Kaufman; and forced isolation readily implies stigmatization. These are all examples of breaking the interpersonal bridge, which Kaufman characterizes as an activator of shame. In Horney's theory we see a description of, but not a direct reference to, shame as a central construct. One reason for this is that, prior to Kaufman's work, there was no coherent vocabulary to accurately label shame. Without such a language, shame could not be readily incorporated as a primary factor in personality development.

Likewise, Erik Erikson (1950) argued that shame occupied an important place in the stages of identity crises that span the life cycle. Erikson related shame specifically to toilet training, the second stage of his life cycle schema, and the outcome of toilet training is autonomy vs. shame and doubt. As Kaufman points out, however,

> in Erikson's conceptualization of each of these recurring crises, it seems evident that each subsequent stage represents a linguistic *transformation of shame.* The poles of each identity crisis include basic trust vs. basic *mistrust*, autonomy vs. *shame and doubt*, initiative vs. *guilt*, industry vs. *inferiority*, identity vs. *role confusion*, intimacy vs. *isolation*, generativity vs. *stagnation*, ego integrity vs. *despair*. Those cognitive symbols reflect differences not in affect per se but in co-assemblies of affect with perceived causes, targets, and consequences. (Kaufman, 1996, p. 9-10)

More recently, a number of theories have emerged which elevate shame to the status of a primary construct in personality development, with those developed by Kaufman (1992, 1996) Kaufman and Raphael (1996), Lewis (1971), Nathanson (1994), Tangney (1995), Wurmser (1981), and Morrison (1983) receiving considerable attention. Each of these theories is somewhat different; and each specifies a somewhat different relationship between shame and other constructs such as guilt, pride, and embarrassment. Yet, many of these theories have significant psychoanalytic underpinnings.

Helen Block Lewis (1971, 1981, 1987a, 1987b), a psychoanalytic theorist, considered the relationship between guilt, shame, identification, and the superego. Guilt and shame are viewed differently by Lewis, although they are considered equally advanced superego functions which develop along different routes of identification. Guilt is generated by identification with an aggressive parent, which then becomes an internalized threat. Shame, in contrast, is generated by identification with the admired ego-ideal, which theoretically stirs feelings of triumph and pride, but leads to shame if one fails to live up to expectations associated with this ideal.

Broucek (1982) and Morrison (1983) also conceptualized shame from a psychoanalytic perspective. In contrast to Lewis's emphases on ego-ideal processes, Broucek considered shame in the context of already established psychoanalytic theory

regarding narcissism and anxiety, as well as narcissism and self-esteem. Additionally, Morrison coupled shame and narcissism with Kohut's Self-Psychology. Together, these theorists helped to move shame to a more prominent position in the field of psychology. Their use of psychoanalytic concepts, however, has also impeded our ability to understand shame in relation to other constructs (Kaufman, 1996). The language of psychoanalysis, which is inherently rooted in drive theory, does not readily integrate the concept of affect, and therefore presents a barrier to theorizing about shame specifically as an affect. Other theories are available which are better able to describe shame and make the construct useful from the vantage point of both theory and research.

Tomkins's (1962) Affect Theory perspective on shame, which has been elaborated by Kaufman (1992, 1996) and incorporated into Kaufman's Shame Theory (Kaufman & Bly, 1995; Kaufman & Raphael, 1991, 1996), provides the soundest means of directly linking the construct of shame to current psychological theory and research.

Affect Theory

Affect theory is the only theory that offers both a model for understanding affect in general and a language for differentiating among particular affects (Kaufman, 1996). In Tomkins's theory, affect is primary over cognition or behavior:

> I see affect or feeling as the primary innate biological motivating mechanism, more urgent than drive deprivation and pleasure and more urgent than even physical pain. Without its amplification, nothing else matters, and with its amplification anything can matter (1987, p. 137)

Other investigations of positive and negative affectivity (Socall, 1995; Watson & Tellegen, 1985; Zevon & Tellegen, 1982) have validated Tomkins's (1962) theory, suggesting two main rudimentary dimensions of moods. Positive affectivity is measured by the extent to which a person feels enthusiastic, active, and alert. Conversely, negative

affectivity is characterized by sadness and lethargy. Research (Watson, Clark, & Tellegen, 1988) shows that positive and negative affectivity represents two major human trait dimensions, consistent with Tomkins's affect theory, but only one empirical study to date (Socall, 1995) has examined the relationship between positive and negative affectivity and the constructs of shame and pride. Socall (1995) found a strong correlation between gay identity-based pride and positive affectivity, as well as a strong correlation between gay identity-based shame and negative affectivity, suggesting that, consistent with affect theory, shame and pride are components of positive and negative affectivity, respectively.

The free and open expression of affect is powerful and highly contagious (Kaufman, 1996). For this reason, all societies have developed regulatory mechanisms in order to govern its expression. For example, public displays of anger and distress (crying) as well as expressions of physical affection between men are socially prohibited (Socall, 1995). Tomkins (1963) posited that shame occupies a unique place in this process because it can be activated by any perceived obstruction to the free expression of the positive affects. To be precise, Tomkins views shame as an auxiliary affect, which means that any impediment that prevents a person from continuing to express positive affect will innately activate shame. Furthermore, since stress is the result of affect suppression, the socialization rules prohibiting the full expression of affect, whether positive or negative, contributes directly to both stress and further shame.

Tomkins (1987) argues that the affects are biologically based and stored in programs located in the central nervous system, and that the face is the central site of affect generation and affect feedback. Tomkins pointed specifically to the skin of the face as the main site for experiencing affect. It is the feedback from changes in facial muscles

that generate the "feeling" of specific affects. Tomkins further argues that the human face's ability to display complex affective information derives from an evolutionary need for a mechanism for generating feedback.

There is a clearly defined set of facial behaviors which both signify and communicate the affect of shame, initially to oneself and subsequently to others. These include hanging the head, lowering or averting the eyes, and blushing (Kaufman, 1996). These facial signals communicate shame and also reduce the exposure associated with shame by limiting visibility of the face.

In contrast to theories which suggest that visceral reactions are the primary location for affective awareness, Tomkins views the outer skeletal and inner visceral responses as the secondary sites for affect expression. Although the affects are innate, they can nevertheless be influenced and modified by environmental experience, especially socialization, and can also become activated by learned triggers.

Affect theory suggests that shame is initially activated whenever there is a partial reduction in positive affect. This can happen, for example, when a person's primary assumptions about himself or herself are exposed as wrong. Thus, if a person believes she is good at a task and then discovers she is not as good as she thought, shame becomes activated. The identical process is observed when a closeted gay man, believing that he finally has the confidence to reveal his true self, suddenly cannot find the courage to do so – causing shame to be activated. In this instance, shame additionally acts as an inhibitory mechanism to the further expression of positive affect.

Shame Theory

According to Kaufman (1992, 1996), the principal way in which shame becomes activated is interpersonally. Typically, shame originates in childhood and is linked directly to the disruption of a child's developmentally based, interpersonal needs. In order to experience secure relationships, children must have their interpersonal needs adequately responded to by care givers. When this does not occur, shame becomes activated. If the lack of responsiveness is only occasional, then shame need not be overwhelming when it does occur, and the child can even develop a healthy awareness of limits as well as increased tolerance for disappointment. However, if the interpersonal context of not having one's needs met becomes too frequent, then the child will search for new meaning in this experience. Since adults inevitably appear infallible and all-powerful to children, a child may conclude, erroneously, that the disappointment and pain caused by these "failed" interactions must be his/her own fault. Because the child blames himself or herself for damaging the relationship, which Kaufman calls breaking the "interpersonal bridge," shame is the inevitable result. Here, shame is activated by any experience that breaks the interpersonal bridge linking the child to a parent or significant other. Following such ruptures, the child begins to develop feelings of not being worthy of love, which is reinforced on each occasion that the child's needs are again not met. Ultimately, these feelings result in the *internalization* of shame – the child becomes convinced that there is something fundamentally wrong with him, and therefore feels inferior.

In further examining the qualities and significance of the interpersonal activators of shame, consider the pre-verbal activators of shame (Kaufman, 1996). The first occasion in which a parent becomes angry with a child can itself activate shame, particularly in the

earliest years before language has developed. The anger of a parent is inevitably experienced by a child as a rupture of the interpersonal bridge, which is the vital nurturing required by every young child. When a newly verbal child experiences parental anger for the first time, that child may respond by saying, in effect, "you don't like me anymore," signaling disruption of the interpersonal bridge. Furthermore, the affective experience of shame is likely to make the child feel additionally powerless, and that powerlessness itself will, in turn, activate additional feelings of shame. Repeated exposure to shame will result in shame experiences becoming gradually more internalized.

The *internalization process* is conceptualized as the ability of the self to reproduce its own experience, which allows the self to both function and develop further. The process of internalization takes place directly through *imagery* (Kaufman, 1996). It is the visual, auditory, and kinesthetic components of internal imagery which enable the self to internalize any affective experience. Both the physiological drives, such as sex and hunger, and the various interpersonal needs require *amplification* by affect. The sex drive, for example, requires fusion with excitement and enjoyment, both positive affects, in order for potency and integration to occur. The first sign of negative affect disrupts sexual pleasure and inhibits the development of satisfying sexual relations.

What ultimately becomes internalized are distinct images that have been imprinted with intense affect. These inner representations develop into *scenes* (Kaufman 1992, 1996). The scene is the event as it is lived or experienced; affect both fuses with and amplifies the scene. Scenes surrounding the expression of affect, interpersonal needs, as well as the sexual and hunger drives, become directly imprinted with affect and then stored in memory. Initially, events amplified with affect are internalized as scenes through

imagery. Later, those scenes can be reactivated by new situations sufficiently similar to old scenes. Scenes can also become *magnified*, a process which involves the fusion and interconnection of different but related scenes.

The process of shame internalization involves repeated association and linking of shame directly to particular affects, drives, and needs. This results in the development of *shame binds* (Kaufman, 1992, 1996), the principal mechanism by which shame internalization comes about. Whenever an experience of an affect, need, or drive is followed by shaming, the two become linked and bound together directly in the resulting scene. The expression of any affect, drive, or interpersonal need can in this way become permanently linked to shame, whether deliberately or inadvertently; that linkage is created simply by the overlap in time. Once created and internalized, the shame bind next functions to spontaneously and indirectly activate shame in the future. Whenever any affect, drive, or interpersonal need, which has become permanently linked to shame, is subsequently experienced or expressed, then shame itself is spontaneously activated. The creation of shame binds enables shame to exercise a powerful, indirect control over behavior.

To illustrate this process, consider a boy who expresses sexual desire toward another boy, which is typically unacceptable in contemporary society; that boy is usually shamed for behaving in this way. When such an experience becomes bound by shame, and these experiences become too shameful to bear, the child will eventually separate himself from those sexual desires, ultimately disowning this shameful part of himself. Consequently, closeted gay men who discover or become aware of reemerging parts of themselves already bound by shame, specifically about homosexuality, will not be able to

experience homoerotic feelings without also experiencing shame. The shame bind results in shame being generated internally and now experienced directly and continually about homosexuality. Being gay has indeed become shameful.

Shame and HIV/AIDS

Although the development of shame binds through affectively linked experiences begins in childhood, it is by no means limited to that developmental epoch. Among People with AIDS and also among homosexual men, the connection between shame and HIV/AIDS, and between shame and homosexuality, can be readily observed. Yet, psychological distress within both the HIV+/AIDS and the homosexual populations are often investigated by looking for the presence of depression, substance abuse, or adjustment disorder. Instead of attempting to force these populations to fit into certain predetermined symptom categories (depression, substance abuse, adjustment disorder), a more fruitful approach would involve assessing the fundamental components embedded in their affective experience.

If psychopathology is a disorder of the affective life as both Tomkins and Kaufman argue, then affect itself must become the focus of inquiry. One such affective component is shame, which is conceptualized as distinct from but certainly a precursor to disorders such as depression or even addiction. Shame is also the affect which lies at the root of the process of stigmatization.

Previous research can be reinterpreted in the light of affect theory. Stigmatizing both HIV infected people and homosexuals results in the inhibition of their ability to freely express their full range of affect. Positive affect is necessarily restricted and negative affect, while made more intense, is also constricted via supression. These conditions cause

a build-up of stress due to "backed-up affect" as well as shame. While people who are HIV+ are, in fact, more likely to develop psychological problems, this derives from their inability to freely express the full range of the primary affects, whether positive or negative. Affect suppression results directly in increased stress, which can be dangerous for the HIV+ patient. In addition, shame is also increased as a direct consequence of HIV illness.

CHAPTER 2
DESIGN OF THE CURRENT STUDY

Prior research has attempted to illuminate the range of psychological disorders commonly experienced by People with AIDS and by homosexuals as well as the widespread societal prejudice still confronting both groups. What has not been examined are the specific affective responses that are triggered within the general population when one is first confronted by HIV/AIDS or by homosexuality. Those affective triggers and responses must be more clearly delineated in order to fully comprehend the process of stigmatization. Only after these affective triggers are clarified can the process of working through those affects and counteracting prejudice proceed effectively.

This study evaluated the affective reactions of male college students when confronted with issues related both to HIV infection and homosexuality. This was accomplished by having each subject read one of four vignettes: The first described a man who has HIV+ status and is homosexual; the second, a man who has HIV+ status and is heterosexual; the third, a man who has Leukemia and is homosexual; and the fourth, a man who has Leukemia and is heterosexual. After reading a vignette, subjects completed questionnaires that measure shame. Subjects completed the questionnaires twice: Once for self and a second time *as if* they were answering for the person described in the vignette. The subjects' responses to the vignettes, which are in effect their "projected" affective experiences, were interpreted through Tomkins's Affect theory and Kaufman's Shame theory.

This study utilized a 2 X 2 X 2 Repeated Measures Analysis of Variance (ANOVA) design with Disease (Leukemia, HIV+) and Sexual Orientation (Heterosexual,

Homosexual), as the independent variables, and ISS scores (Self, Projected) as the Target of the shame ratings factor.

Based on hypotheses put forth by Affect Theory and Shame Theory, this study predicted that HIV+ status would be the most significant variable in generating shame responses from subjects. The second most significant variable for generating shame responses was predicted to be homosexuality. Moreover, it was predicted that an Interaction Effect would be observed when HIV+ status and homosexuality are combined: the combination of HIV+ status and homosexuality would produce a level of shame greater than the sum of these two parts. Theoretically, this would be true even for a man who is comfortable and well adjusted to homosexuality because learning of his HIV+ status would trigger re-enactments of old shame scenes relating to homosexuality, further combining shame, anger, fear, and disgust with homosexuality and with HIV+ status.

Hypothesis One. The first hypothesis predicted that differences between ISS-self and ISS-projected shame ratings would interact with Disease (Leukemia, HIV) and Sexual Orientation (Heterosexual, Homosexual). This would be demonstrated by a significant 3-Way Interaction. Support for this hypothesis would be further demonstrated by follow-up paired samples t-tests indicating the largest increase in shame ratings between ISS-self and ISS-projected scores when subjects rated the vignette with both HIV+ status and Homosexuality; the second largest increase in shame ratings would be generated in response to the vignette describing a man who has an HIV+ status and who is Heterosexual; the third largest increase in shame ratings would be generated in response to the vignette describing a man who has Leukemia and who is Homosexual; and the smallest increase in shame ratings would be generated in response to the vignette describing a man

who has Leukemia and who is Heterosexual.

Hypothesis Two. The second hypothesis predicted that shame on the Affect Inventory would interact with Disease (Leukemia, HIV) and Sexual Orientation (Heterosexual, Homosexual). This would be demonstrated by a significant 2-Way Interaction. Support for this hypothesis would be further demonstrated by a Multivariate Analysis of Variance (MANOVA) indicating that when subjects read the vignette describing HIV+ status and Homosexuality, the highest scores would be generated for affect adjectives that load heavily on the "Shame" sub-scale; the second highest score on the "Shame" sub-scale would be generated for vignettes describing HIV+ status and Heterosexuality; the third highest score on the "Shame" sub-scale would be generated for vignettes describing Leukemia and Homosexuality; and the lowest score on the "Shame" sub-scale would be generated for vignettes describing Leukemia and Heterosexuality.

CHAPTER 3
METHOD

Subjects

The subjects were 131 men, the majority of whom were undergraduate students. A student population was thought to be representative of the larger population in that some subjects may be openly gay and some "closeted," while the majority will be heterosexual and healthy. Subjects either received extra credit in their courses in exchange for their participation or were entered into a raffle for the chance to be one of four students to win $25.00.

In deciding how many subjects to test, it would have been desirable, when computing item analyses on newly developed measures (i.e., the Affect Inventory), to have at least 10 subjects for each variable being tested because 10 subjects per variable would provide a high degree of reliability in the results and permit greater generalizability of those results. This would have required approximately 400 subjects, however, and such an endeavor was not feasible. Instead, 131 subjects were tested and the data from those subjects were interpreted cautiously.

Materials

The materials used in this study included an Informed Consent form (Appendix A), Demographic Information Questionnaire (Appendix B), Sexual Orientation Questionnaire (Appendix C), Current Health Status Questionnaire (Appendix D), four vignettes describing specific characteristics of a man named "Mark" (Appendix F, G, H, I), first and second administrations of the ISS (Appendix E and J), Affect Inventory (Appendix K), and a Brief Statement (Appendix L).

Informed Consent. The Informed Consent Form stated: "This is a study which looks at people's understanding and empathy toward other people who are in a situation which is either different from your own situation or similar to your own situation. This is a 'normative study' which means we do not currently know how normal people, such as you, will respond, and we want you to help us find out. It is anticipated that your participation in this experiment will take about one hour and you will receive research credit for your participation." The task subjects were asked to complete are listed in the Informed Consent: Demographic Information Questionnaire, Sexual Orientation Questionnaire, Health Status Questionnaire, ISS Questionnaire, one vignette, Adjective Inventory Checklist, and to write a few sentences explaining your responses.

Demographic Information Questionnaire. The Demographic Information Questionnaire requested the following information: subjects' age, year in school, ethnicity/race, religious identification while growing up, current religious identification, and academic major. These data were used to examine possible differences among the four subject groups that might confound tests of the research hypotheses.

Sexual Orientation Questionnaire. Preliminary data was also gathered on subjects' sexual orientation. As described by Socall (1995), the Assessment of Sexual Orientation Scale (Coleman, 1987) generates data on sexual orientation using a multidimensional method. In developing this scale, Coleman augmented the "classic" Kinsey homosexual-heterosexual continuum by expanding it from the single question used by Kinsey. A shortened version of Coleman's (1987) instrument was used by Socall (1995) and was used here to gather information about subjects' present sexual orientation identification, future desired sexual orientation identification, and comfort level with current sexual

orientation. Also included were questions which ask about subjects' current relationship status, whether subjects know others who are gay, and the status of that relationship (i.e., friends, family, acquaintance).

Current Health Status Questionnaire. Information was gathered regarding subjects' current health status, frequency of high risk behavior for contracting HIV, history of HIV testing, and current HIV Serostatus. Also included were questions about HIV knowledge and personal experiences with HIV+ populations.

Internalized Shame Scale. The Internalized Shame Scale (ISS), developed by Cook (1994), is a 30-item self-report questionnaire that assesses the extent to which subjects have internalized painful levels of shame. Subjects were asked to rate the frequency with which they experience the emotions described in each item. Ratings are made on a 5-point Likert scale (0 = Never to 4 = Almost Always) with higher scores representing more internalized shame. The shame scale instrument is made up of 24 negatively-worded shame items and a second scale, made up of six items, which is used to measure "self-esteem" and to lessen the tendency for a response set to develop when all "shame items" are worded in the same direction" (Cook, 1994).

The ISS was standardized using both clinical and non-clinical populations. The non-clinical subject population used in the normative data sample (N = 645) comprised undergraduate and graduate students. This sample also consisted of both male (32%) and female (68%) students. The subjects' mean age was 24 years (SD = 8; range = 17-63), 75% were single, and approximately 86% were white, 10 % Native American, and the remainder comprised other minorities.

Factor analyses of the ISS have revealed two shame factors: Inferiority and Alienation. The Inferiority scale, however, accounts for 75% of the total variance and the two scales are correlated significantly with each other (0.77 - 0.83). Since these two scales have a high degree of overlap, Cook (1994) has argued that the two scales probably will not contribute differential information. The ISS, therefore, is typically used as a single scale measuring internalized shame (Cook, 1994).

Cook (1994) reported reliability data for both clinical (alpha = .96) and non-clinical (alpha =.95) populations and reported a median item-total correlation of 0.70 in the clinical sample and .63 in the non clinical sample.

The validity data for the ISS are offered as a comparison to other measures of disturbances of emotional life. The data are presented this way because shame is considered both an auxiliary affect to the positive affects and also an affect that is fundamental in self-development. Therefore, shame can exert an impact on a wide range of psychological disorders, and it has been compared to various other diagnostic instruments.

The ISS was compared to the Brief Symptom Checklist (i.e., SCL-50), a 50-item version of the SCL-90 instrument. Using a sample of 336 adult out-patient psychotherapy clients, the correlations among the ten scales of the SCL-50 (Depression, Somatic, Obsessive-compulsive, Interpersonal sensitivity, Anxiety, Hostility, Psychoticism, Phobic anxiety, Paranoid ideation, and Guilt), and the ISS ranged between 0.45 and 0.74, all significant at the $p<0.01$ level. These correlations "confirm the pervasive role played by shame emotions in the psychopathology of a clinical population" (Cook, 1994, p. 21).

In another validity test, the ISS was compared to the Parental Bonding Instrument

(PBI) developed by Parker (1983). The PBI is a 24-item scale that yields scores for the dimensions of care (related to warmth and nurturance) and protection (related to a pattern of intrusiveness and over-control). High scores represent either a high level of care and nurturance or a high level of over-control and intrusiveness. Adult parents complete the measure by remembering how their parenting was experienced during childhood.

The sample included 155 non-clinical subjects and 200 clinical subjects. The scales were labeled "mother care," "mother protection," "father care," and "father protection." The "direction of the correlations indicates that a high level of care and nurturance is associated with lower shame and high control and intrusiveness is associated with higher levels of internalized shame" (Cook, 1994). Correlations for three of the four scales (mother care, mother protection, father protection) were significant at $p \leq .01$. The other scale (father protection) was significant at $p \leq .05$. These results suggest that the ISS has good construct validity and also can be used to evaluate a wide range of emotional disturbances.

When scoring the ISS, a shame score is calculated by removing the six positively worded items (items 4, 9, 14, 18, 21, and 28) and then summing the numerical responses to the remaining 24 items. The shame score can range from 0-96. Raw scores can then be compared to normative data and significant differences evaluated.

Affect Inventory. The Affect Inventory, a new measure, was developed and used in this study for the first time. The list of affects was taken from Tomkins's and McCarter's (1964) list of Neutral plus eight other primary affect pairs: 1) Interest – Excitement; 2) Surprise – Startle; 3) Distress – Sad; 4) Joy – Happy; 5) Afraid – Frightened; 6) Angry – Mad; 7) Disgusted – Loathing; 8) Shame – Humiliation. Each

affect was labeled to represent both low and high intensity. For example, the affect Interest is a low-to-moderate intensity affect and Excitement is the same affect at a high intensity level (Demos, 1995, p. 218). In Tomkins's and McCarter's (1964) research on the primary affects, they also generated a brief list of alternative words which can be used to signify each affect. In order to test their hypothesis that these affects are innate and recognized by most people when one's face displays the experience of any given affect, Tomkins and McCarter instructed subjects to view photographs of faces which portrayed each primary affect. The subjects' task was to determine which affect was expressed in each photograph by selecting from a list the appropriate primary affect or its alternative in order to describe the facial expression.

In general, statistically significant results showed that subjects were successful in matching the affect words to the appropriate facial expression. The correlations between the primary affect and affect posed in the photograph ranged from .631 to .988 ($\underline{N} = 24$). These correlations suggest that these affect words strongly relate to the affect presented in the photographs. Their study utilized 40 adjectives, including those categorized as Neutral, all of which were shown to accurately describe various displayed emotions.

In the current study, a total of thirty-six adjectives were selected, the majority of which were taken from Tomkins's and McCarter's (1964) original list, along with additional affect adjectives written for this study and selected through consultation with an expert in affect theory and shame theory.

The adjectives used here were randomly listed and placed along side a 5-point Likert Scale (1 = never, 5 = almost always). The randomization was accomplished by creating a list of adjectives and then placing each adjective onto its own strip of paper.

Next, the strips of paper were placed in a bowl and thoroughly mixed, after which one strip was removed at a time and set aside. The first adjective selected in this manner was placed first on the list. The second adjective picked was placed second, and so on. This process was repeated until all adjectives had been selected and placed in sequence on the list.

To complete the Affect Inventory, subjects were asked to rate the frequency with which they believe the man named Mark in each vignette experiences each affect on the inventory. Answers were recorded on a 5-point Likert scale (1 = Never, 5 = Almost Always) and higher scores represent more of that emotion.

Procedure

Prior to data collection, 131 subject packets were created and numbered 001 through 131. Packets 001 through 031 included the HIV+ and homosexual vignette; packet 032 through 062 included the HIV+ and heterosexual vignette; packet 063 through 093 included the Leukemia and homosexual vignette; and packet 094 through 131 included the Leukemia and heterosexual vignette. All packets also included the other measures described earlier. The packets were distributed to the participants in random order.

Subjects were tested in a group/classroom setting. Each subject was given a packet and asked to remove its entire contents. The Informed Consent Form was on top and all subjects were asked to read and sign the Informed Consent Form if they were willing to participate. The Informed Consent Forms were collected and scanned for signatures. All participating subjects were reminded that they were free to stop participation at any time without penalty.

Subjects were then asked to complete the next items in their packet including the Demographic Information Questionnaire, the Sexual Orientation Questionnaire, and the Current Health Status Questionnaire.

The ISS was completed next. The directions were read aloud by the experimenter and the subjects were instructed to complete the ISS. This scale was used to measure the subjects' own level of internalized shame.

Next, subjects were asked to read the vignette in their packet and complete the second ISS form, this time answering the questions as if they were reporting how the man in the vignette, Mark, actually feels. After the second ISS was completed, all subjects completed an Affect Inventory. Finally, subjects were asked to write a few short sentences reporting why they believe "Mark" feels the way he does.

After all measures were completed, subjects were asked to replace all of their forms in the packet folder and their folders were collected. A debriefing period followed, and any questions were answered at that time.

Data Analysis

All statistical procedures were performed using the Statistical Package for Social Science (SPSS) and only findings resulting in $p \leq .05$ were considered significant.

General Statistical Procedures

Frequencies and descriptive statistics were generated for all data recorded on the Demographic, Sexual Orientation, and Current Health Status questionnaires (see Appendix M for details). Additionally, in order to examine whether subjects in each group were comparable on the data collected via the Demographic, Sexual Orientation, and Current Health Status questionnaires, a One-Way Analysis of Variance (ANOVA) across

all groups was computed.

Data Analysis for Hypothesis One. To test the 3-Way-Interaction between Disease (Leukemia, HIV+), Sexual Orientation (Heterosexual, Homosexual), and ISS scores (Self, Projected), a Repeated Measures Analysis of Variance was computed using Disease (Leukemia, HIV+) and Sexual Orientation (Heterosexual, Homosexual) as between–subject variables, and ISS scores (Self, Projected) as Target of shame ratings factor.

Data Analysis for the Affect Inventory and Hypothesis Two. Because the Affect Inventory is a new instrument, a Principal Components Analysis (PCA) was computed. Inter-item correlations, inter-scale correlations, mean-item correlations, and variances were calculated. Any items that decreased reliability on sub-scales were evaluated and, if warranted, dropped from further analyses. Following this, an Exploratory Factor Analysis using the PCA solutions was computed.

Next, two Multivariate Analyses of Variance (MANOVAs) were used to analyze the data related to the second hypothesis. The first MANOVA evaluated the possible Interaction Effect between Disease (Leukemia, HIV), Sexual Orientation (Heterosexual, Homosexual), and the six Negative Adjective sub-scales. The second evaluated the possible Interaction between Disease (Leukemia, HIV), Sexual Orientation (Heterosexual, Homosexual), and the two Positive Adjective sub-scales.

CHAPTER 4
RESULTS

Demographic Information

A One-Way Analysis of Variance (ANOVA) was computed across all using the Demographic, Sexual Orientation, and Current Health Status Questionnaires, to assess possible differences between each group of subjects. Groups were defined by experimental condition. Group one comprised subjects who read the vignette identifying Mark as a homosexual and as diagnosed HIV+; Group two comprised subjects who read the vignette identifying Mark as a heterosexual and as diagnosed HIV+; Group three comprised subjects who read the vignette identifying Mark as a homosexual and as diagnosed with Leukemia; and Group four comprised subjects who read the vignette identifying Mark as a heterosexual and as diagnosed with Leukemia (see Appendix M for descriptive statistics).

One significant difference was found between groups. Significantly more subjects who identified their "race"as nonwhite on the Demographic Questionnaire were in Group one compared to any other group. Therefore, analyses were computed to determine the extent, if any, of the relationship between the Demographic variable Race and ISS ratings. The results showed that Race did not have a significant effect on ISS ratings $F(1, 123), = .28$, $p = .6$.

Results of Primary Predictions

Results for Hypothesis One. The first hypothesis predicted a 3-Way-Interaction between Disease, Sexual Orientation, and ISS ratings, the Target of shame ratings factor. The 3-Way-Interaction was not significant $F(1, 109) = .041$, $p = .84$. Only the Main

Effect for Target of shame ratings factor was significant $F(1, 109) = 29.17$, $p = .000$, indicating significant differences between ISS-self scores and ISS-projected scores across all vignette conditions (see Table 1).

Neither of the 2-Way interactions, between Disease and Target or between Sexual Orientation and Target, were significant. However, there was a significant difference between group effects for Disease that was not predicted $F(1, 109) = 8.32$, $p = .005$. In other words, both Leukemia and HIV+ status produced significant increases in ISS-projected scores compared to ISS-self scores. Another finding surprisingly showed that both ISS-self and ISS-projected group ratings were lower, meaning less shame, for the groups reading vignettes describing Leukemia $t = (129) = -2.04$, $p = .043$, than for the groups reading vignettes describing HIV+ status $t = (126.4) = -1.91$, $p = .058$, even though subjects had been randomly assigned to each condition. As seen in Table 1, however, the difference in mean scores between ISS-Self and ISS-Projected scores was not significantly different between groups.

Analysis of the Affect Inventory & Results for Hypothesis Two. Hypothesis two posited that a 2-Way Interaction between Disease (Leukemia, HIV) and Sexual Orientation (Heterosexual, Homosexual) would be found for Affect Inventory adjectives loading heavily on shame. Furthermore, the rank order predicted for Hypothesis One was also predicted to be generated by the Affect Inventory. In other words, the highest score on the "Shame"sub-scale would be generated for vignettes describing HIV+ status and Homosexuality; the second highest score on the "Shame"sub-scale would be generated for vignettes describing HIV+ status and Heterosexuality; the third highest score on the "Shame" sub-scale would be generated for vignettes describing Leukemia and

Homosexuality; and the lowest score on the "Shame" sub-scale would be generated for vignettes describing Leukemia and Heterosexuality.

Before testing this hypothesis, a Principal Component Analysis was computed to reduce the Affect Inventory data. Originally, nine sub-scales including Distress (4-items, alpha = .77), Anger (4-items, alpha = .83), Dissmell (4-items, alpha = .84), Disgust (4-items, alpha = .85), Afraid (4-items, alpha = .85), Shame (4-items, alpha = .89), Joy (4-items, alpha = .86), Interest (4-items, alpha = .77), and Surprise (4-items, alpha = .57), were used in the analysis. In two instances, sub-scale items were dropped because they reduced some sub-scale's internal reliability. The dropped items were "Aggression" from the "Anger sub-scale" and "Lonely" from the "Distress sub-scale." Also, the entire sub-scale "Surprise" was dropped since it was internally inconsistent. After dropping the two unreliable adjectives, and dropping the sub-scale "Surprise," the overall internal consistency and reliability of the Affect Inventory had Sub-scale Alpha Coefficients ranging from 0.77 to 0.89 and each item had a Corrected Item-Total Correlation of .50 or above. Table 2 shows Sub-scale Alpha Coefficients and Corrected Item-Total Correlations for each item, including those items and scales that were dropped. Table 3 shows the correlation matrix for the remaining eight sub-scales.

The remaining eight sub-scales were Factor Analyzed using an Exploratory Factor Analysis and two Factors were found. Table 4 shows the sub-scale loadings for each factor. The first factor, called the Negative Affect Factor, included six sub-scales; 1) Distress, 2) Angry, 3) Dissmell, 4) Disgust, 5) Afraid, 6) Shame. The second factor, called the Positive Affect Factor, included two sub-scales; 1) Joy and 2) Interested.

Following this to test Hypothesis Two, a MANOVA was performed using the six

sub-scales associated with the Negative Affect Factor (Distress, Angry, Dissmell, Disgust, Afraid, Shame) as dependent variables, and Disease (Leukemia, HIV), and Sexual Orientation (Heterosexual, Homosexual) as independent variables. This analysis did not support the second research hypothesis; the 2-Way Interaction between Disease and Sexual Orientation was not significant (Wilks' Lambda $F(6, 116) = .73$, $p = .63$). In addition, neither of the two Main Effects was significant. Similarly, no significant effects resulted from the second 2 X 2 MANOVA, substituting the two sub-scales from the Positive Affect Factor (Joy, Interested) as dependent variables (Wilks' Lambda $F(2, 120) = .262$, $p = .77$). Table 5 shows Affect Inventory mean scores for each group.

CHAPTER 5
DISCUSSION

Through the lens of Affect Theory and Shame Theory, this study evaluated the affective reactions of college men when confronted with issues related to HIV infection and homosexuality. Two predictions were investigated, neither of which were supported. However, after submitting the Affect Inventory to an Exploratory Factor Analysis of the Principal Component Analysis' solutions, the Affect Inventory was found to have statistically sound construction. Also, unanticipated significant results pertaining to subjects' reactions to the variable Disease were discovered, as well as unexpected subject-selection findings.

Discussion of the Affect Inventory

The Affect Inventory is a modified list of adjectives taken from Tomkins et al. (1964). Although this study was not primarily intended to create a new measure of affect, it has nevertheless served to create a measure which, as others have hypothesized, (Socall, 1995; Tomkins, 1962; Watson & Tellegen, 1985; Zevon & Tellegen, 1982), clearly identified two primary affective states, Negative and Positive. The Negative Adjective factor is comprised of six sub-scales describing negative affects (i.e., Distressed, Afraid, Angry, Disgusted, Shame, Dissmell) and the Positive Adjective factor is comprised of two sub-scales describing positive affects (i.e., Joy, Interested).

As shown in Table 3, the correlations between the sub-scales Shame, Dissmell, and Disgust are particularly strong. This implies that subjects did not perceive the adjectives within these sub-scales as different from each other. These sub-scales, therefore, did not discriminate the subjects' affective reactions. This is an important issue when determining the strength of the Affect Inventory in a research setting. In the future, one may choose to

combine adjectives from these sub-scales and attempt to add an additional sub-scale which would discriminate affective reactions more effectively.

However, the lack of discrimination makes sense when considered within the context of Affect Theory and Shame Theory. Tomkins (1987), Kaufman (1996), and Kaufman and Raphael (1996) believe that Dissmell and Disgust are emotions which lead to the experience of Shame, are "shame-based" adjectives, and are intimately connected to the experience of shame. It is possible therefore, that the clinician trained in Affect Theory and Shame Theory would readily identify the differences between Disgust, Dissmell, and Shame, while those who are less focused on the nuances of affective experiences would not readily identify the differences. This issue is worthy of consideration when the Affect Inventory is used in future research.

Nevertheless, the Affect Inventory reliably identifies adjectives which express feelings associated with shame. This is significant because one drawback of earlier attempts to understand and explore shame was the lack of an appropriate language with which to describe shame (Tomkins's, 1962; Kaufman, 1992, 1996; Kaufman & Bly, 1995; Kaufman & Raphael,1991,1996). The Affect Inventory, as developed here, furthers our ability to understand shame by crystallizing a language that captures this elusive emotion and this sets the stage for further exploration. Also, one of the adjectives included in the Affect Inventory (i.e., Dissmell) which applies to the shame construct as Kaufman has outlined (1996), was found to correlate highly with other adjectives that are thought to be shame-based, as well as with the adjective "shame" itself (.74) (see Table 3). As Kaufman (1996) states, Dissmell is defined by Tomkins (1987) as an "innate defensive response, functioning in an auxiliary manner to the oxygen, thirst, and hunger drives" (p. 13).

Dissmell serves to protect human beings from noxious objects via a facial reaction of raising the upper lip and nose, while simultaneously drawing-back the head, thereby reducing one's closeness from noxious smelling stimuli. Dissmell is a distancing, rejecting affect. Since Dissmell is shown here to be correlated with the affect of shame, it is assumed that Dissmell played a role in subjects' shame-based responses, especially toward Disease. Given the close association between disease and contamination, this makes theoretical sense.

Also, although the differences were not significant, the Affect Inventory Mean scores produced a rank order consistent with the predicted results (see Table 5). Since these findings failed to reach significance, and because this measure is new, the results must be interpreted cautiously and must be independently replicated. Still, the Affect Inventory offers new opportunities to examine shame and therefore it warrants future research consideration.

Discussion of the Primary Prediction

Hypothesis One. The first hypothesis predicted a 3-Way-Interaction between Disease (Leukemia, HIV), Sexual Orientation (Heterosexual, Homosexual), and ISS ratings (Self, Projected), the Target of shame ratings factor. The findings did not support this hypothesis. The assumption underlying this hypothesis was that the stimulus value of confronting a person who is HIV+ and Homosexual would produce shame in the subjects, leading them to project their shame onto the person with the undesirable characteristics, and thereby stigmatize the individual possessing these characteristics. Based on a combination of Goffman's Stigmatization Theory (1963), Tomkins's Affect Theory (1962), and Kaufman's Shame Theory (Kaufman, 1992, 1996; Kaufman & Bly, 1995;

Kaufman & Raphael, 1991, 1996), this should have been true even for subjects with high levels of internalized shame (i.e., ISS-self score) because even those who experience high levels of internalized shame should be able to place distance between themselves and others whom they view as outside of "normal."

In this study, subjects did express higher levels of projected shame, as measured by the ISS, compared to internalized shame, also measured by the ISS (see Table 2). Subjects did not, however, appear to project shame based on specific Diseases or specific Sexual Orientations. Although the 3-Way-Interaction was not significant, there was a significant finding for the Main Effect Disease. Again, this showed that both Leukemia and HIV+ status produced significant increases in ISS-projected scores compared to ISS-self scores.

There are multiple reasons why subjects who participated in this study experienced high levels of shame toward disease in general, but did not specifically attribute shame to people who are HIV+. One explanation could be related to the fact that many of the subjects are too young to remember a time when HIV/AIDS did not exist. The average age of the subjects in this study was almost 21-years (μ_{age}= 20.72) and the modal age was 19-years. When the first signs of the AIDS illness were becoming known to hospitals in the United States in 1979 (Curran, 1983), and the first AIDS related deaths were reported by the CDC in 1981 (Batchelor, 1984; Nicholas, 1983), many of these subjects had not yet been born. It is possible that, having grown up during a time when HIV/AIDS has always been a known entity reduces one's perception of "difference" about HIV+ people compared to others who are seriously ill with a different disease.

Another explanation for an increased and generalized shame response to disease

might be related to an unexpected impact of the characteristics describing Mark, the man in the vignettes. Mark was intentionally described using characteristics with which many college students could identify. Although the vignettes were designed with the intention to increase the subject's identification with Mark, it was not anticipated that subjects' reactions would be the same for all vignettes. Although all subjects read vignettes which described a man who ultimately regained his health sufficiently to continue his daily living, the illnesses were described as "serious" and it is assumed that participants recognize that HIV and Leukemia are both potentially fatal. For most people, thinking about death evokes intense emotional experiences. As Kaufman (1996) suggests, death is thought to be "the universal symbol of ultimate human powerlessness" (p. 53) and thus, death is a potential activator of distress and shame. Moreover, people in their early twenties do not often consider their own mortality; young people often "feel invincible." If these assumptions are valid, then the subjects' unexpected confrontation with descriptions of a potentially fatal disease affecting someone they could identify with may have changed their experience toward the HIV and Leukemia variables; death may have dominated their emotional experiences, leading subjects to "ignore" the type of illness and react only to the potential outcome.

Unexpected Group Differences. Unexpectedly, subjects who ultimately read vignettes describing Leukemia had lower mean ISS-self scores ($\mu_{\text{ISS-selfscoresGroup3}} = 24.17$, $\mu_{\text{ISS-selfscoresGroup 4}} = 20.90$) than subjects who ultimately read vignettes describing HIV+ status ($\mu_{\text{ISS-selfscoresGroup1}} = 26.48$, $\mu_{\text{ISS-selfscoresGroup2}} = 29.47$). For more details, see Table 1. This finding is perplexing given that all subjects were randomly assigned to groups. Moreover, as shown in Appendix M, all groups were similar when compared on

Demographic, Sexual Orientation, and Current Health Status Questionnaires.

Brief Statement

Subjects were also instructed to "Describe why you think the man in the vignette, Mark, feels the way the way he does." Although subjects' responses in their Brief Statement were reviewed, they were not analyzed. Subjects put forth a variety of reasons for their projected responses. Some specifically wrote that Mark felt "shame" for being gay, some assumed AIDS was transmitted through homosexual encounters, even when Mark was identified as a heterosexual (i.e., lover was Roberta) and others expressed anger as a dominant affect experienced by Mark. Often, the anger was directed toward his disease, which may translate into the increased likelihood for a young death. Still, others expressed sympathy for Mark having HIV and having Leukemia, depending on the vignette they read. No group patterns were readily identifiable regarding either Sexual Orientation or Disease.

Future Research

Affect Inventory. Future investigations may benefit from using the Affect Inventory twice for each person. When considering the benefits of the ISS data collected for this study, the decision to use pre – and post – data allowed for the evaluation of affective change over time, an impossible analysis with only one set of data. One could easily mimic this study's approach to ISS data collection, but also include the Affect Inventory early in the process, collecting an Affect Inventory-self rating in addition to an Affect Inventory-projected rating.

Statistical Power and Effect Size. On the Affect Inventory, findings revealed non-significant differences between group means, although the mean scores did follow the hypothesized rank order suggesting a possible trend. Although it may not be feasible for many researchers, one suggestion for future research would be to increase statistical power by dramatically increasing the number of subjects in each group. Increasing power may indeed yield significant results.

Vignettes. What may be more feasible than attracting more subjects, however, would be to increase the effect size of the vignettes. In other words, by more clearly distinguishing each variable, one may get more distinct responses. This could be accomplished by clarifying the vignette descriptions of Sexual Orientation and Disease and offering clearer and more descriptive statements about each Sexual Orientation and about each Disease. Since this study was predicated on the idea that subjects would respond to the Sexual Orientation and Disease variables, identifying these variables more directly and discussing them more expansively ought not to adversely change the integrity of the study. For example, instead of using the names "Robert and Roberta" to identify Mark's lover and thus identify his Sexual Orientation, one could choose more clearly distinct names like "Alan and Stacy." Alternatively, one could make a direct reference to Mark's Sexual Orientation by openly labeling him homosexual or heterosexual and also use more explicit names to identify his lover. In clarifying the Disease variables, one could describe common symptoms, identify common routes of transmission, and specify the way in which the person in the vignette contracted their respective diseases. Caution should be taken, however, to try and minimize differences between variables. For example, if the description of the HIV+ person is that of an IV drug user who contracted HIV from

sharing dirty needles, one might have a different reaction to that person compared to the person who contracts Cancer through contamination resulting from a chemical spill. Similarly, different feelings may be evoked toward the HIV+ person who contracted the Virus from their HIV+ mother while in *utero* compared to the IV drug user. Using more similar examples, such as contracting HIV through sharing dirty needles and contracting Lung Cancer from smoking two packs of non-filtered cigarettes per day may help balance the vignettes.

Additionally, one could choose to add a different type of "control vignette" to the study. For instance, a vignette could be inserted after the self-rating of the ISS which would identify Mark as both heterosexual and healthy. The original vignettes could remain the same or be modified in ways described above. One might expect multiple levels of shame to be produced; one for self, one for Mark when he is defined as heterosexual and healthy, and a third and fourth depending on the Sexual Orientation and Disease status of the subsequent vignettes.

Finally, while the demographic variable "religion" did not impact the results reported in the current study, it may nevertheless be useful to include a Religiosity Questionnaire. By doing so, one could more clearly determine whether different levels of religious beliefs impact ratings. It might be predicted that the more explicit the vignettes are in describing sexual orientation issues, routes of transmission, and other details and definitions, the more likely one's conservative or liberal biases would influence affective reactions and thus ratings. It may be useful to have information related not only to one's religious preference, but also to understand the possible impact of the level of religious connection.

Different Subjects. The characteristics of subjects who are chosen to participate in future studies need to be considered. Perhaps most clinically interesting would be to include an additional group of male subjects who are either HIV+ or homosexual. However, if the results of such a study were to produce results similar to those presented here, one could argue that the projections made in this study were accurate, even though the hypotheses were not supported. If the results were significantly different when HIV+ men or homosexual men were the subjects, not only would the current findings be less meaningful, but new information regarding the feelings of people who actually deal with these issues would then be available. This is additionally important because understanding the inner experience of individuals is a necessary part of any clinical undertaking.

Another group that could shed new light on this topic would be female subjects. This would require adding vignettes which have females experiencing the same problems as Mark. Also, female testers should be considered, to balance any possible effect from sex-differences resulting from the sex of the tester. The benefits of such changes may outweigh the challenges. For instance, because homophobia continues to be a problem in our culture, and tends to be more problematic for men than women, having women participate may lead to more information about sex differences when confronting homosexuality in men.

The possibilities for future research in the area of stigmatization of homosexuals and People with HIV/AIDS are considerable. Further research is important in order to expand knowledge of the processes involved in stigmatization. It is also important in order for therapists to have a more effective impact working with these clients and anyone struggling with these issues.

Clinical Implications

The clinical implications of this and similar research relate directly to clinicians' ability to work effectively with homosexuals, HIV+ people, and others who are in contact with these individuals. Since 1973 when the American Psychological Association removed homosexuality from the list of disorders in the DSM III (Morin & Rothblum, 1991), research focusing on psychologists' and medical staffs' willingness to provide services to homosexuals and HIV+ people shows a continuing pattern of stigmatization toward those populations (St. Lawrence, Kelly, Owen, & Hogan, 1990; Kelly, St. Lawrence, Smith, Hood, & Cook, 1988; Kelly, St. Lawrence, Smith, Hood, & Cook, 1987a; Kelly, St. Lawrence, Smith, Hood, & Cook, 1987b). Still other researchers have noted that the mental health profession's stigmatizing practices often create iatrogenic wounds when serving these clients while simultaneously limiting the chances that these people would continue to seek basic services readily available to others. Finally, when HIV+ people experience stress, their immune system may suffer irreparable damage, and failing to help these people reduce their stress adds an additional burden to their condition. This strongly indicates the need for increased understanding, through research, of the counter-transference experienced when professionals are confronted with homosexuality and HIV-infected people. If we do not actively pursue knowledge about the unwarranted prejudice communicated by professionals, we not only fail to help this population but we also risk creating additional harm.

There are still other important reasons for professionals to further their insight into their own counter-transference reactions and into the needs of these two groups. One of the most useful approaches to working with the issues faced by HIV+ people is through

support groups (Ruhala & Woodring, 1993; Sherr, 1995). Compared to individual therapy, the group offers an opportunity to serve many clients at one time, often accommodating as many as twelve individuals. One of the reported benefits of these support groups is the opportunity to meet with others without concern about being treated as an outcast (i.e., stigmatized) and without the need to explain one's condition, risking problematic responses. If, however, psychologists are less willing to facilitate this type of group, thereby limiting the number of groups available, many will suffer from limited access to services.

Additionally, where HIV is concerned, the results generated by this type of research would extend beyond helping individuals who are HIV+. In recent years, many mental health agencies have recognized the need to offer services to family members, spouses/partners, and care givers of HIV+ people. There are now support groups for Couples who are Sero-discordant (one partner HIV+, one partner HIV–); for Family and Friends of HIV+ people; for Grandparents Raising HIV+ Grandchildren; and for HIV+ Care Givers (AIDS Resource Guide, Baltimore, 2000). These groups have reported tremendous difficulty maintaining client membership. One possible reason for diminished attendance may relate to the facilitators' limited understanding of the specific affects generated when people are confronted with HIV. Since precise affective reactions to HIV are still unknown, it is possible that group leaders are not able to easily understand the inner experience of their group members. When misunderstandings are recognized but no satisfying remedies are available, then a clinical impasse is easily reached, which has been hypothesized to lead to dropping out (Dr. Anne Yenchko, personal communication, September 4, 2000). The research presented here, therefore, is not limited to helping

People with HIV/AIDS, but impacts all of the people living with and working with issues related to HIV/AIDS.

One last clinical implication relates to the way in which medical knowledge and treatment regimes alter the societal impact of HIV/AIDS and also vicariously impact homosexual communities. The medical information available concerning HIV/AIDS, coupled with the speed with which new information is generated, increases the likelihood that HIV/AIDS will become a chronic, manageable illness, similar to diabetes and high blood pressure. If treatment of HIV/AIDS were to reach this stage, but many professionals continued to be resistant to working with this population, then the perceived need to attend to people with this illness will remain low and this could provide an excuse for continued under-involvement by mental health professionals. This would be an unfortunate outcome. If psychologists continue to resist working with this population, the clinical implications will almost certainly result in increased death rates for HIV+/AIDS populations.

Conclusions

Although this study did not produce significant results, the lack of significance does not necessarily mean that such evidence is absent. Instead, these findings should encourage researchers to redouble their efforts to find the data that will explicate the attitudes of many people in society toward People with HIV/AIDS, as expressed by Buckley Jr. (1986) and Robinson (1987), and the present research findings. Additionally, some data suggests that homosexuals are perceptively connected to HIV/AIDS (Brauer, 1994; Bennet, 1987; Crandall, Glor, & Britt, 1997; DeMarco, 1998; Herek & Glunt, 1988, 1991; Kaufman, 1996; Kaufman & Raphael, 1996; Limandri, 1989; Morin, Charles,

Maylon, 1984; Morin & Rothblum, 1991), increasing the need to better understand and work more effectively with this population as well.

The Affect Inventory is a promising new measure for studying shame because it appears to accurately identify shame-based affect. In this study, the Affect Inventory was easy to administer, easy to score, and appeared statistically sound. Nevertheless, because it is new additional research is necessary to further validate both its usefulness and statistical construction.

Theoretically driven research, in this case the guiding theories put forth by Tomkins, Kaufman, and Goffman, is particularly useful because it offers the unique contribution of a language that most accurately describes shame. It must be left to future research to clarify and substantiate how these theories best apply to HIV and to homosexuality.

APPENDIX A

APPENDIX A

Informed Consent

This is a study which looks at peoples' understanding and empathy toward other people who are in a situation which is either different from our own situation or similar to our own situation. This is a "normative study" which means we do not currently know how normal people, such as you, will respond, and we want you to help us find out. It is anticipated that your participation in this experiment will take about 20-25 minutes and for your participation I will include $5.00 as a token of my appreciation.

If you choose to participate in this study, you will be one subject out of a total of approximately 120. All subjects' records will be kept confidential. To ensure this, you will be assigned a subject number, which will be the only way to identify you in any reports about this study. Only the experimenter will have access to the files and lists which could be used to link a name with a subject number. Any publications from this work will not identify you by name or in any way that would allow your identity to be discovered.

For this study you will be asked to complete several tasks.

1. On the *Subject Identification Form*, you will be asked to write your name. This is the only form that can identify you by name and link you to the subject identification number that has been assigned to you. Only the experimenter and his designates will have access to your file. To ensure confidentiality, all other documents you fill out will have only your subject identification number.

2. On the *Demographic Information Questionnaire*, you will be asked to provide

your age, ethnicity, religion, years of education, and academic major.

3. On the *Sexual Orientation Questionnaire,* you will be asked to provide information about your current sexual orientation identification; your future desired sexual orientation identification; how comfortable you are with your current sexual orientation; current relationship status; and whether you know people who are gay and, if so, the nature of your relationship to them.

4. On the *Health Status Questionnaire,* you will be asked to provide information about high risk sexual behavior; whether you have been tested for HIV serostatus; if so, when you were and what the results were; whether you know anyone who is or was HIV+; and what their current health status is, and the nature of their relationship to you.

5. On the *ISS,* you will be asked to complete a questionnaire which asks how often you experience certain feelings.

6. Next you will be asked to read one of four vignettes. Each vignette describes a person and includes a variety of characteristics. After reading the vignette you will be asked to complete another ISS. The questionnaire will ask you to decide how often you think the subject in the vignette experiences certain feelings/affects.

7. Next you will be asked to complete an Adjective Inventory. The instructions for this measure will ask that you decide how often you think the subject in the vignette experiences certain feelings/affects.

8. Then you will be asked to write a few sentences explaining why you think the person in the vignette feels the way he does.

APPENDIX A (con't.)

A debriefing period will follow your participation in the experiment. You will receive one hour of research credit for your participation. You have the right to discontinue your participation at any time and for any reason, and to do so without explanation or penalty. There is also an alternative method of earning extra course credit if you do not wish to participate in this or other experiments. If you wish to seek this alternative, speak with your Introductory Psychology professor for specifics. The assignment may vary from professor to professor, but it usually involves writing a short paper.

If you would like further information regarding your rights as a research subject, you may contact the Office of the UCRIHS at Michigan State University by telephoning (517) 355-2180.

After the entire study is completed, if you have any questions or if you want a written summary of the general results, you may contact the investigator at his university office.

I have read this consent form, I understand the conditions, and I voluntarily agree to participate in this study.

_____ _____

Subject's Signature Date

_____ _____

Investigator's Signature Date

APPENDIX B

APPENDIX B

SUBJECT DEMOGRAPHICS

1) Age: ____

2) Ethnic or Racial Identification:

_____ Black/African American

_____ Hispanic, Chicano, Latino, or Mexican American

_____ White or Caucasia

_____ Asian/Oriental/Pacific Islander

_____ Native American (specify)

_____ Other _____

3) Highest Level of Education:

____ Less than High School diploma

____ High School diploma

____ Some college, no degree

____ Bachelor's degree

____ Associates degree

____ Masters, professional degree or Beyond

4) If you were raised with a specific religious preference, what religion was it?

____ Catholic ____ Protestant ____ Jewish ____ Buddhist

____ Muslim ____ Presbyterian ____ Hindu ____ None

____ Other _____
(Please specify)

5) With which religion do you currently identify, if any?

____ Catholic ____ Protestant ____ Jewish ____ Buddhist

____ Muslim ____ Presbyterian ____ Hindu _____ None

____ Other _____
(Please specify)

APPENDIX B (Con't.)

6) What is your Academic Major?

____ Psychology ____ Engineering ____ Business

____ Hotel/Restaurant Management ____ Forestry ____Education

____ Other _____
(Please specify)

APPENDIX C

APPENDIX C

SEXUAL ORIENTATION DATA

1) In terms of my present sexual orientation, I identify myself as . . .

____ Exclusively homosexual

____ Predominantly homosexual

____ Bisexual

____ Predominantly heterosexual

____ Exclusively heterosexual

____Unsure

2) In my future, I would like to identify myself as . . .

____ Exclusively homosexual

____ Predominantly homosexual

____ Bisexual

____ Predominantly heterosexual

____ Exclusively heterosexual

____ Unsure

3) In terms of comfort with my current sexual orientation, I would say that I am . . .

____ Very comfortable ____ Mostly Comfortable ____ Comfortable

____ Not very comfortable ____ Very Uncomfortable

APPENDIX C (con't.)

4) What is your current relationship status?

____ Single, no sexual partners

____ Single, one committed partner

____ Single, multiple partners

____ Coupled, living together (Committed to an exclusive sexual relationship)

____ Coupled, living together (Relationship permits other sexual partners under certain circumstances)

____ Coupled, living apart (Committed to an exclusive sexual relationship)

____ Coupled, living apart (Relationship permits other sexual partners under certain circumstances)

____ Other (please specify) _____

5) Do you know people who are gay?

____ Yes ____ No

5a) If yes, are they your . . .

____ Family Member ____ Friend ____ Acquaintance ____ Other

APPENDIX D

APPENDIX D

CURRENT HEALTH STATUS

1) How many times have you engaged in "high risk sexual behavior" with a woman (i.e., having sexual intercourse without using a condom)?

____ 0 times ____ between 1 and 5 times ____ between 6 and 10 times

____ between 11 and 15 times ____ between 16 and 20 times ____ more than 20 times

2) How many times have you engaged in "high risk sexual behavior" with a man (i.e., having sexual intercourse without using a condom)?

____ 0 times ____ between 1 and 5 times ____ between 6 and 10 times

____ between 11 and 15 times ____ between 16 and 20 times ____ more than 20 times

3) Have you ever been tested for the Human Immunodeficiency Virus (HIV)?

____ Yes ____No

4) If you have been tested for HIV, when was your last test performed?

____ within the last 3 months ____ between 3 months and 6 months ago

____ between 6 months and 12 months ago ____ between 12 months and 24 months ago

____ over 24 months ago

5) Did the results show that you are/were . . .

____ HIV positive ____ HIV negative

____ Unclear results

6). Do you currently know or have you known in the past anyone who is HIV+?

____ Yes ____ NO

6a) If yes, how close do you feel you are/were to that person?

____ Very close ____ Somewhat close ____ Acquaintance

____ Not particularly close ____ Not close at all

APPENDIX D (con't)

7) Is/was that person a member of your immediate family?

____ Yes ____ No

7a. If yes, was it your. . .

____ Mother ____ Father ____Brother ____ Sister

____ Aunt ____ Uncle ____ Other_____
(Please specify)

8) What is that person's current health status?

____ Alive and physically well

____ Alive but with failing health

____ Died from HIV/AIDS related medical issues

____ Died of something unrelated to HIV/AIDS

____ Other _____
(Please specify)

APPENDIX E

APPENDIX E

Internalized Shame Scale

Directions: Below is a list of statements describing feelings or experiences that you may have had from time to time or that is familiar to you because you may have had these feelings and experiences for a long time. Most of these statements describe feelings or experiences that are generally painful or negative in some way. Some people will seldom or never have some of these feelings. Everyone has had some of these feelings at some time. If you find that these statements describe the way you feel a good deal of the time, it can be painful just reading them. Try to be as honest as you can in responding.

Read each statement carefully and circle the number to the right of the item **that indicates the frequency with which you find yourself** feeling or experiencing what is described in the statement.

	Never	**Seldom**	**Sometimes**	**Frequently**	**Almost Always**
1. I feel that I am never quite good enough.	1	2	3	4	5
2. I feel somehow left out.	1	2	3	4	5
3. I think that people look down on me.	1	2	3	4	5
4. All in all, I am inclined to feel that I am a success.	1	2	3	4	5
5. I scold myself and put myself down.	1	2	3	4	5
6. I feel insecure about others opinion of me.	1	2	3	4	5
7. Compared to other people I feel like I somehow never measure up.	1	2	3	4	5
8. I see myself as very small and insignificant.	1	2	3	4	5
9. I feel I have much to be proud of.	1	2	3	4	5
10. I feel intensely inadequate and full of self-doubt.	1	2	3	4	5
11. I feel as if I am somehow defective as a person, like there is something basically wrong with me.	1	2	3	4	5

APPENDIX E (con't.)

	Never	Seldom	Sometimes	Frequently	Almost Always
12. When I compare myself to others I am just not as important.	1	2	3	4	5
13. I have an overpowering dread that my faults will be revealed in front of others.	1	2	3	4	5
14. I feel I have a number of good qualities.	1	2	3	4	5
15. I see myself striving for perfection only to continually fall short.	1	2	3	4	5
16. I think others are able to see my defects.	1	2	3	4	5
17. I could beat myself over the head with a club when I make a mistake.	1	2	3	4	5
18. On the whole, I am satisfied with myself.	1	2	3	4	5
19. I would like to shrink away when I make a mistake.	1	2	3	4	5
20. I replay painful events over and over in my mind until I am overwhelmed.	1	2	3	4	5
21. I feel I am a person of worth at least on an equal plane with others.	1	2	3	4	5
22. At times I feel like I will break into a thousand pieces.	1	2	3	4	5
23. I feel as if I have lost control over my body functions and my feelings.	1	2	3	4	5
24. Sometimes I feel no bigger than a pea.	1	2	3	4	5

APPENDIX E (con't.)

	Never	Seldom	Sometimes	Frequently	Almost Always
25. At times I feel so exposed that I wish the earth would open up and swallow me.	1	2	3	4	5
26. I have this painful gap within me that I have not been able to fill.	1	2	3	4	5
27. I feel empty and unfulfilled.	1	2	3	4	5
28. I take a positive attitudes toward me myself.	1	2	3	4	5
29. My loneliness is more like. emptiness.	1	2	3	4	5
30. I feel like there is something missing.	1	2	3	4	5

APPENDIX F

APPENDIX F

Vignette

Mark, a 20-year-old college student at a large Midwestern university, is a hard working student studying computer programing. Mark is an outgoing person who has lived on campus since he arrived at college, although he is currently thinking about moving to an off-campus apartment. His interests include surfing the Internet, going to movies and pubs, and he has many sports related interests as well.

Over the last few months Mark has been experiencing a number of health-related problems. These have included fatigue, physical decline such as weight loss, poor appetite, and restless sleep, as well as recurrent infections. When Mark went to his doctor, he found out that he was seriously ill; He was diagnosed as having Human Immunodeficiency Virus (HIV+).

Mark's family, including his mother, father, older sister, and older brother had a difficult time dealing with his illness. Also, even though it was difficult to see Mark not feeling well, the seriousness of Mark's illness drew his longstanding romantic partner, Robert, even closer to him.

Although he took five years, Mark went on and finished college, receiving a degree in computer programing. Mark is still HIV+, but with medication and continued support from Robert he can continue to engage in those things he always enjoyed: surfing the Internet, going to movies and pubs, and sports.

APPENDIX G

APPENDIX G

Vignette

Mark, a 20-year-old college student at a large Midwestern university, is a hard working student studying computer programing. Mark is an outgoing person who has lived on campus since he arrived at college, although he is currently thinking about moving to an off-campus apartment. His interests include surfing the Internet, going to movies and pubs, and he has many sports related interests as well.

Over the last few months Mark has been experiencing a number of health-related problems. These have included fatigue, physical decline such as weight loss, poor appetite, and restless sleep, as well as recurrent infections. When Mark went to his doctor, he found out that he was seriously ill; He was diagnosed as having Human Immunodeficiency Virus (HIV+).

Mark's family, including his mother, father, older sister, and older brother had a difficult time dealing with his illness. Also, even though it was difficult to see Mark not feeling well, the seriousness of Mark's illness drew his longstanding romantic partner, Roberta, even closer to him. Although he took five years, Mark went on and finished college, receiving a degree in computer programing. Mark still has HIV+, but with medication and continued support from Roberta he can continue to engage in those things he always enjoyed: surfing the Internet, going to movies and pubs, and sports.

APPENDIX H

APPENDIX H

Vignette

Mark, a 20-year-old college student at a large Midwestern university, is a hard working student studying computer programing. Mark is an outgoing person who has lived on campus since he arrived at college, although he is currently thinking about moving to an off-campus apartment. His interests include surfing the Internet, going to movies and pubs, and he has many sports related interests as well.

Over the last few months Mark has been experiencing a number of health-related problems. These have included fatigue, physical decline such as weight loss, poor appetite, and restless sleep, as well as recurrent infections. When Mark went to his doctor, he found out that he was seriously ill; He was diagnosed as having Leukemia (cancer).

Mark's family, including his mother, father, older sister, and older brother had a difficult time dealing with his illness. Also, even though it was difficult to see Mark not feeling well, the seriousness of Mark's illness drew his longstanding romantic partner, Robert, even closer to him. Although he took five years, Mark went on and finished college, receiving a degree in computer programing. Mark still has Leukemia, but with medication and continued support from Robert he can continue to engage in those things he always enjoyed: surfing the Internet, going to movies and pubs, and sports.

APPENDIX I

APPENDIX I

Vignette

Mark, a 20- year-old college student at a large Midwestern university, is a hard working student studying computer programing. Mark is an outgoing person who has lived on campus since he arrived at college, although he is currently thinking about moving to an off-campus apartment. His interests include surfing the Internet, going to movies and pubs, and he has many sports related interests as well.

Over the last few months Mark has been experiencing a number of health-related problems. These have included fatigue, physical decline such as weight loss, poor appetite, and restless sleep, as well as recurrent infections. When Mark went to his doctor, he found out that he was seriously ill; He was diagnosed as having Leukemia (cancer).

Mark's family, including his mother, father, older sister, and older brother had a difficult time dealing with his illness. Also, even though it was difficult to see Mark not feeling well, the seriousness of Mark's illness drew his longstanding romantic partner, Roberta, even closer to him. Although he took five years, Mark went on and finished college, receiving a degree in computer programing. Mark still has Leukemia, but with medication and continued support from Roberta he can continue to engage in those things he always enjoyed: surfing the Internet, going to movies and pubs, and sports.

APPENDIX J

APPENDIX J

Internalized Shame Scale

Directions: Below is a list of statements describing feelings or experiences that you may have had from time to time or that is familiar to you because you may have had these feelings and experiences for a long time. Most of these statements describe feelings or experiences that are generally painful or negative in some way. Some people will seldom or never have some of these feelings. Everyone has had some of these feelings at some time. If you find that these statements describe the way you feel a good deal of the time, it can be painful just reading them. Try to be as honest as you can in responding.

Read each statement carefully and circle the number to the right of the item **you think Mark, the man in the vignette, experiences what is described in the statement**.

	Never	**Seldom**	**Sometimes**	**Frequently**	**Almost Always**
1. I feel that I am never quite good enough.	1	2	3	4	5
2. I feel somehow left out.	1	2	3	4	5
3. I think that people look down on me.	1	2	3	4	5
4. All in all, I am inclined to feel that I am a success.	1	2	3	4	5
5. I scold myself and put myself down.	1	2	3	4	5
6. I feel insecure about others opinion of me.	1	2	3	4	5
7. Compared to other people I feel like I somehow never measure up.	1	2	3	4	5
8. I see myself as very small and insignificant.	1	2	3	4	5
9. I feel I have much to be proud of.	1	2	3	4	5
10. I feel intensely inadequate and full of self-doubt.	1	2	3	4	5
11. I feel as if I am somehow defective as a person, like there is something basically wrong with me.	1	2	3	4	5

APPENDIX J (con't)

	Never	Seldom	Sometimes	Frequently	Almost Always
12. When I compare myself to others I am just not as important.	1	2	3	4	5
13. I have an overpowering dread that my faults will be revealed in front of others.	1	2	3	4	5
14. I feel I have a number of good qualities.	1	2	3	4	5
15. I see myself striving for perfection only to continually fall short.	1	2	3	4	5
16. I think others are able to see my defects.	1	2	3	4	5
17. I could beat myself over the head with a club when I make a mistake.	1	2	3	4	5
18. On the whole, I am satisfied with myself.	1	2	3	4	5
19. I would like to shrink away when I make a mistake.	1	2	3	4	5
20. I replay painful events over and over in my mind until I am overwhelmed.	1	2	3	4	5
21. I feel I am a person of worth at least on an equal plane with others.	1	2	3	4	5
22. At times I feel like I will break into a thousand pieces.	1	2	3	4	5
23. I feel as if I have lost control over my body functions and my feelings.	1	2	3	4	5
24. Sometimes I feel no bigger than a pea.	1	2	3	4	5

APPENDIX J (con't)

	Never	Seldom	Sometimes	Frequently	Almost Always
25. At times I feel so exposed that I wish the earth would open up and swallow me.	1	2	3	4	5
26. I have this painful gap within me that I have not been able to fill.	1	2	3	4	5
27. I feel empty and unfulfilled.	1	2	3	4	5
28. I take a positive attitudes toward me myself.	1	2	3	4	5
29. My loneliness is more like. emptiness.	1	2	3	4	5
30. I feel like there is something missing.	1	2	3	4	5

APPENDIX K

APPENDIX K

Affect Inventory

Directions: Below is a list of words which describe affects or feelings. Please read each word carefully and circle the number to the right of the word that indicates the frequency with which you think **the subject in the vignette you just read experiences the affect described here**. Use the scale below and try to be as accurate as you can in responding.

	Never	Seldom	Sometimes	Frequently	Almost Always
1. Aggressive	1	2	3	4	5
2. Alert	1	2	3	4	5
3. Contaminated	1	2	3	4	5
4. Panicky	1	2	3	4	5
5. Terrified	1	2	3	4	5
6. Delighted	1	2	3	4	5
7. Disgusting	1	2	3	4	5
8. Smiling	1	2	3	4	5
9. Pained	1	2	3	4	5
10. Excited	1	2	3	4	5
11. Frightened	1	2	3	4	5
12. Loathing	1	2	3	4	5
13. Amazed	1	2	3	4	5
14. Smelly	1	2	3	4	5
15. Scornful	1	2	3	4	5
16. Angry	1	2	3	4	5

APPENDIX K (con't)

	Never	Seldom	Sometimes	Frequently	Almost Always
17. Surprised	1	2	3	4	5
18. Petrified	1	2	3	4	5
19. Soiled	1	2	3	4	5
20. Inferior	1	2	3	4	5
21. Attentive	1	2	3	4	5
22. Distressed	1	2	3	4	5
23. Sad	1	2	3	4	5
24. Joyful	1	2	3	4	5
25. Revolting	1	2	3	4	5
26. Exposed	1	2	3	4	5
27. Startled	1	2	3	4	5
28. Polluted	1	2	3	4	5
29. Worthless	1	2	3	4	5
30. Focused	1	2	3	4	5
31. Lonely	1	2	3	4	5
32. Furious	1	2	3	4	5
33. Shocked	1	2	3	4	5
34. Hostile	1	2	3	4	5
35. Pleased	1	2	3	4	5
36. Humiliated	1	2	3	4	5

APPENDIX L

APPENDIX L

Brief Statement

In the space provided, please describe why you think the man in the vignette, Mark, feels the way he does?

APPENDIX M

APPENDIX M

Descriptive Statistics for Demographic Questionnaire Variables

WHAT IS YOUR AGE?

Subjects Age	Frequency	% of Total Subjects
18	11	8.40
19	31	23.70
20	29	22.10
21	26	19.80
22	22	16.80
23	4	3.10
24	2	1.50
25	2	1.50
26	1	0.80
31	1	0.80
34	1	0.80
36	1	0.80

ETHNIC/RACIAL IDENTIFICATION?

Race	Frequency	% of Total Subjects
Black\African-American	6	4.60
Hispanic\Chicano\Latino\ Mexican-American	3	2.30
White\Caucasian	96	73.30
Asian\Pacific Islander	19	14.50
Native American	0	0.00
Other	7	5.30

APPENDIX M (Con't.)

Descriptive Statistics for Demographic Questionnaire Variables

LEVEL OF EDUCATION?

Education	Frequency	% of Total Subjects
Less than High School	1	0.80
High School Diploma	8	6.10
Some College/No Degree	94	71.80
Associates Degree	4	3.10
Bachelor's Degree	21	16.00
Masters/Professional Degree	3	2.30

RELIGIOUS BACKGROUND?

Religious Background	Frequency	% of Total Subjects
Catholic	46	35.10
Protestant	29	22.10
Jewish	11	8.40
Buddhist	2	1.50
Muslim	2	1.50
Presbyterian	6	4.60
Hindu	0	0.00
None	22	16.80
Other	13	9.90

APPENDIX M (Con't.)

Descriptive Statistics for Demographic Questionnaire Variables

CURRENT RELIGIOUS PREFERENCE?

Religious Background	Frequency	% of Total Subjects
Catholic	29	22.10
Protestant	22	16.80
Jewish	11	8.40
Buddhist	4	3.10
Muslim	2	1.50
Presbyterian	5	3.80
Hindu	0	0.00
None	38	29.00
Other	20	15.30

ACADEMIC MAJOR?

Major	Frequency	% of Total Subjects
Psychology	13	9.90
Engineering	25	19.10
Business	17	13.00
Hotel\Restaurant Management	2	1.50
Forestry	2	1.50
Education	1	0.80
Other	71	54.20

APPENDIX M (Con't.)

Descriptive Statistics for Sexual Orientation Questionnaire Variables

CURRENT SEXUAL ORIENTATION?

Current Sexual Orientation	Frequency	% of Total Subjects
Exclusively Homosexual	1	0.80
Predominantly Homosexual	2	1.50
Bisexual	2	1.50
Predominantly Heterosexual	12	9.20
Exclusively Heterosexual	113	86.30
Unsure	1	0.80

DESIRED SEXUAL ORIENTATION?

Desired Sexual Orientation	Frequency	% of Total Subjects
Exclusively Homosexual	1	0.80
Predominantly Homosexual	2	1.50
Bisexual	2	1.50
Predominantly Heterosexual	13	9.90
Exclusively Heterosexual	113	86.30
Unsure	0	0.00

APPENDIX M (Con't.)

Descriptive Statistics for Sexual Orientation Questionnaire Variables

COMFORT W/CURRENT SEXUAL ORIENTATION?

Comfort w/ Current Sexual Orientation	Frequency	% of Total Subjects
Very Comfortable	115	87.90
Mostly Comfortable	9	6.90
Comfortable	6	4.60
Not Very Comfortable	0	0.00
Very Uncomfortable	1	0.80

CURRENT RELATIONSHIP STATUS?

Relationship Status	Frequency	% of Total Subjects
Single, No Sexual Partners	76	58.00
Singe, One Committed Partner	25	19.10
Single, Multiple Partners	5	3.80
Coupled, Living Together (Committed to an Exclusive Sexual Partner)	5	3.80
Coupled, Living Together (Relationship Permits Other Sexual Partners Under Certain Circumstances)	0	0.00
Coupled, Living Apart, (Committed to One Sexual Partner)	17	13.00
Coupled, Living Apart (Relationship Permits Other Sexual Partners Under Certain Circumstances)	1	0.80
Other	2	1.50

APPENDIX M (Con't.)

Descriptive Statistics for Sexual Orientation Questionnaire Variables

DO YOU KNOW PEOPLE WHO ARE GAY?

Know Gay People	Frequency	% of Total Subjects
Yes	106	80.60
No	25	19.10

IF YOU DO KNOW PEOPLE WHO ARE GAY, ARE THEY YOUR?

Who Do You Know	Frequency	% of Total Subjects
Family Member	13	9.90
Friend	57	43.50
Acquaintance	36	27.50
Other	25	19.10

APPENDIX M (Con't.)

Descriptive Statistics for Current Health Status Questionnaire Variables

HIGH RISK SEXUAL BEHAVIOR WITH WOMEN?

High Risk w/Women	Frequency	% of Total Subjects
0 times	70	53.40
Between 1 & 5 Times	36	27.50
Between 6 & 10 Times	4	3.10
Between 11 & 15 Times	3	2.30
Between 16 & 20 Times	2	1.50
More than 20 Times	16	12.20

HIGH RISK SEXUAL BEHAVIOR WITH MEN?

High Risk w/Men	Frequency	% of Total Subjects
0 times	128	97.70
Between 1 & 5 Times	1	0.80
Between 6 & 10 Times	1	0.80
Between 11 & 15 Times	0	0.00
Between 16 & 20 Times	0	0.00
More than 20 Times	1	1.80

HAVE YOU EVER BEEN TESTED FOR HIV?

HIV Test	Frequency	% of Total Subjects
Yes	25	19.10
No	106	80.90

APPENDIX M (Con't.)

Descriptive Statistics for Current Health Status Questionnaire Variables

RESULTS FROM HIV TEST?

HIV Status	Frequency	% of Total Subjects
Never Been Tested	108	82.40
HIV+	0	0.00
HIV –	22	16.80
Unclear Results	1	0.80

DO YOU KNOW CURRENTLY OR HAVE YOU KNOWN IN THE PAST ANYONE WHO IS HIV+?

Know HIV+ People	Frequency	% of Total Subjects
Unanswered	13	9.90
Yes	12	9.20
No	105	80.20

HOW CLOSE DO YOU FEEL YOU ARE/WERE TO THE HIV+ PERSON?

Closeness	Frequency	% of Total Subjects
Unanswered	116	88.50
Very Close	2	1.50
Somewhat Close	3	2.30
Acquaintance	3	2.30
Not Particularly Close	3	2.30
Not Close at All	3	2.30

APPENDIX M (Con't.)

Descriptive Statistics for Current Health Status Questionnaire Variables

IS/WAS THE HIV+ PERSON A MEMBER OF YOUR IMMEDIATE FAMILY?

Family Member	Frequency	% of Total Subjects
Unanswered	119	90.80
Yes	0	0.00
No	12	9.20

IF THEY WERE A FAMILY MEMBER, WERE THEY YOUR?

Relative	Frequency	% of Total Subjects
Unanswered	129	97.90
Mother	0	0.00
Father	0	0.00
Brother	0	0.00
Sister	0	0.00
Aunt	0	0.00
Uncle	0	0.00
Other	2	1.50

APPENDIX M (Con't.)

Descriptive Statistics for Current Health Status Questionnaire Variables

WHAT IS THE PERSON'S CURRENT HEALTH STATUS?

Current Health	Frequency	% of Total Subjects
Unanswered	119	91.60
Alive & Physically Well	5	3.80
Alive but w/Failing Health	1	0.80
Died from HIV/AIDS Related Illness	5	3.80
Died from Something Unrelated to HIV/AIDS	0	0.00
Other	0	0.00

Table 1: Mean scores for Internalized Shame Scale-Self ratings and Projected ratings and the Amount of Change between scores.

Internalized Shame Scale Scores

Group	N	ISS-Self	ISS-Projected	Difference
1	42	26.48	37.57	11.09
2	30	29.37	39.37	10.00
3	29	24.17	35.93	11.76
4	30	20.90	29.80	8.90

Note: For ISS-Projected Mean Scores, Group 1 = Homosexual & HIV+;
Group 2 = Heterosexual & HIV+; Group 3 = Homosexual & Leukemia;
Group 4 = Heterosexual & Leukemia.

Table 2. Affect Inventory Sub-scale, Adjectives, Corrected Item-Total Correlations, and Sub-scale Alpha scores.

Sub-Scale Headings & Affect Adjectives	Corrected Item-Total Correlations	Sub-Scale Alpha Scores
DISTRESSED		.77
Distressed	.49	
Sad	.69	
Pained	.57	
~~Lonely~~	~~.36~~	
AFRAID		.85
Panicky	.56	
Frightened	.75	
Petrified	.71	
Terrified	.73	
ANGRY		.83
Angry	.63	
Furious	.64	
Hostile	.58	
~~Aggressive~~	~~.03~~	
DISGUST		.85
Loathing	.68	
Disgusting	.63	
Scornful	.71	
Revolting	.77	

Table 2. (Continued)

SHAME		.89
Inferior	.80	
Exposed	.66	
Humiliated	.81	
Worthless	.77	
DISSMELL		.84
Smelly	.63	
Soiled	.73	
Polluted	.77	
Contaminated	.58	
INTERESTED		.77
Excited	.56	
Attentive	.68	
Alert	.50	
Focused	.55	
JOY		.86
Joyful	.71	
Smiling	.73	
Pleased	.73	
Delighted	.68	
~~**SURPRISED**~~		~~.57~~
~~Surprised~~	~~.51~~	
~~Startled~~	~~.39~~	
~~Amazed~~	~~.17~~	
~~Shocked~~	~~.38~~	

Note: Strike-out lines indicate adjectives and data dropped from subsequent analyses.

Table 3: Correlation Matrix for eight Affect Inventory Sub-Scale headings.

	Distress	**Angry**	**Dissmell**	**Joy**	**Disgust**	**Interest**	**Afraid**	**Shame**
Distress	1.00	.69	.59	– .49	.64	– .39	.76	.60
Angry	.69	1.00	.63	– .46	.79	– .36	.67	.70
Dissmell	.59	.63	1.00	– .50	.71	– .37	.60	.74
Joy	– .49	– .46	– .50	1.00	– .52	.72	– .34	– .57
Disgust	.64	.79	.71	– .52	1.00	– .40	.63	.82
Interest	– .39	– .36	– .37	.72	– .40	1.00	– .28	– .41
Afraid	.76	.67	.60	– .34	.63	– .28	1.00	.62
Shame	.60	.70	.74	– .57	.82	– .41	.62	1.00

Table 4. Component Matrix of factor loadings on the two factor solution revealed by an Exploratory Factor Analysis of the Affect Inventory.

Variables	**Negative-Adjective Factor**	**Positive-Adjective Factor**
Distress	.82	.16
Angry	.85	.21
Dissmell	.82	.10
Joy	−.70	.61
Disgust	.88	.13
Interest	−.59	.72
Afraid	.78	.36
Shame	.87	6.345E-02

Table 5: Mean scores and Standard Deviations on the Negative-Affect Factor of the Affect Inventory.

Group	N	Mean Score	Standard Deviation
1	42	109.00	14.21
2	30	107.73	16.76
3	29	105.21	15.52
4	30	102.40	14.54

Note: Group number corresponds to vignette scenarios; Group 1 = Homosexual & HIV+; Group 2 = Heterosexual & HIV+; Group 3 = Homosexual & Leukemia; Group 4 = Heterosexual & Leukemia.

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