

THE RELATIONSHIP OF GUILT PRONENESS  
AND SHAME PRONENESS AMONG  
AFRICAN AMERICAN WOMEN

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## CHAPTER I

### INTRODUCTION

#### **Black Women and Depression**

Jones and Shorter-Gooden (2006) noted that Black women may express depressive symptoms in traditional ways, such as sadness or loss of interest in activities, as well as through alternative means, such as upholding strenuous responsibilities (i.e., having multiple jobs). The authors suggested that some Black women fit into the ‘Sisterella’ complex in which they experience depressive symptoms through means of internalizing anger, feelings of guilt, feelings of inadequacy and low self-worth, internalizing negative messages about one’s self (i.e., shame) instead of externalizing messages about one’s self; experiencing more somatic complaints than usual (i.e., headaches), and they may tend to neglect their own basic needs by being completely selfless and more focused on other individuals (Jones & Shorter-Gooden, 2006). Jones and Shorter-Gooden further explained that Black women who experience such depressive symptoms will try to compensate or cope by engaging in behaviors such as overeating or binge eating, alcohol abuse, substance use, and/or by being fixated on their appearance (i.e., placing extreme focus on hair, clothing, or makeup). Brown, Ahmed, Gary, and

Milburn (1995) conducted a study that focused on the risk factors of African American men and women developing major depressive disorder. The researchers looked at sociocultural factors, physical health, SES, and other demographic information such as gender, and age in order to examine the prevalence of major depressive disorder within their sample. The study consisted of approximately 865 African American men and women between the ages of 18-20 years old. The researchers utilized the Diagnostic Interview Schedule (DIS) to gather information about the sample's prevalence of major depressive disorder, depressive symptoms, and mental health history (Brown et al., 1995).

Demographic information was collected to develop an understanding about the various cultural factors, and the participants self-reported their overall physical health and current life circumstances with the Rahe's Recent Life Change Questionnaire (Brown et al., 1995). The results of the study revealed several interesting findings regarding major depressive disorder and African Americans. First, Brown and fellow's (1995) expressed that their results demonstrated a higher number of African Americans experiencing major depressive disorder in comparison to an earlier study conducted by the National Institute of Mental Health (NIMH): Epidemiologic Catchment Area (ECA). Secondly, Brown and colleagues indicated the sample's major depressive disorder prevalence had a very significant association with younger age groups and among those in poor overall physical health. Major depressive symptoms were further related to self-reports of difficult life circumstances, and being transient within a five year period which was independently related to a decrease in age and a decrease in overall physical health (Brown et al., 1995).

The study did not reveal any strong associations with major depressive disorder, gender variation, and SES (Brown et al., 1995).

Brown and colleagues (1995) suggested that their results may be a reflection of sociocultural inferences of the African American community. For example, the researchers highlighted that when examining the physical health of the participants, trends such as hypertension, diabetes, and other health problems were definitely pronounced among their sample. Moreover, the researchers mentioned that experiencing a loss of community or prominent social support during a recent move may contribute to major depressive disorder within the African American community. This may imply that examining cultural influences is of extreme importance when identifying major depressive disorder in some African Americans (Brown et al., 1995).

Lastly, Brown et al., (1995) explained that the members within their sample sought help through means of a primary care physician rather than a mental health professional. As mentioned previously, the study showed that major depressive disorder was associated with younger age and decreased physical health which may imply that African Americans might seek help from a medical doctor, rather than a mental health professional, as some symptoms of major depressive disorder may manifest in somatic form (Brown et al., 1995). The researchers noted that participants did not specify if those who sought treatment from a medical doctor intended to gain help solely for symptoms typically related to depression. Nevertheless, the researchers recommended that additional education and research is needed for African Americans with major depressive disorder because oftentimes their symptoms may be undiagnosed and masked by other contributing factors such as decreased physical health (Brown et al., 1995).



A study conducted by Etowa, Keddy, Egbeyemi and Eghan (2007) focused on depressive symptoms among a sample of women who self identified as Black Canadian. The researchers collected data at baseline that included information about their health status, their views on depressive symptoms, racism, prejudice stressors, views on healthy living, and additional quantitative and qualitative information concerning well-being. The participants in the study included women between the ages of 40 to 65 years-old within the Nova Scotia community, who participated in a structural interview, focus-group meetings, community workshops, and completed the Centre for Epidemiological Studies on Depression questionnaire (CES-D; Etowa et al., 2007).

Etowa and colleague's (2007) study revealed that Black Canadian women handled their depressive symptoms by utilizing spiritual outlets, and seeking social support from family and peers. The investigators suggested that Black Canadian women's depressive symptoms manifest as a result of their life stressors (i.e., racism, sexism, overall well-being, low SES, and other social/environmental distresses). In conjunction with this, the study's findings suggested that this sample considered depression a taboo subject, and therefore the women attempted to avoid and ignore the emotional significance of the disorder and minimize it by considering depressive symptoms as a component of life (Etowa et al., 2007). The study showed that Black women's rates of depressive symptoms on the CES-D were greater than White women's reports of depressive symptoms (Etowa et al., 2007). However, the study also demonstrated that the Black women were less likely to seek professional help. Etowa and colleagues (2007) inscribed that mental health professionals were not attuned to the experiences that women from diverse backgrounds endure, and also that mental health professionals may have a

difficult time identifying depressive symptoms because Black women may have a tendency to rationalize their symptoms as a part of their everyday life.

Other researchers have aimed to find an association between an individual's personal perception of African American racial identity, also known as private regard, and society's perception of African Americans, known as public regard (Settles, Navarrete, Pagano, Abdou, & Sidanius, 2010). The researchers hypothesized that Black women's levels of increased, or positive, public and private perceptions of their race/culture would be related to decreased rates of depressive symptoms, that strong racial identity would mediate levels of public and private regard and contribute to lower rates of depressive symptoms, and that self-esteem would mediate levels of public and private regard and have an association with decreased levels of depressive symptoms. Their sample included 379 African American females between the ages of 18 and 64 years old (Settles et al., 2010). Participants completed three measures assessing their levels of racial identity, depressive symptoms, and self-esteem. Three subscales of the Multidimensional Inventory of Black Identity (MIBI) were used to measure public regard, private regard, and levels of African American racial identity (i.e., racial centrality; Settles et al., 2010). The MIBI traditionally consists of eight subscales but for the purposes of the Settles and fellow's study only the three mentioned components were self-reported by the participants. The Beck Depression Inventory-II (BDI-II) consisted of 21 responses that allowed the participants to self-rate their current depressive symptomology. The Rosenberg Self-Esteem Scale was used to measure the participant's levels of self-esteem, and it consisted of 10 responses in which the participant's self-esteem could range from high (or more positive) to low (or more negative; Settles et al., 2010).

Settles and colleagues (2010) found that African American's self-perception of their race, public/societal perception of the African American race, and levels of self-esteem were related to depressive symptoms. Specifically, low rates of depressive symptoms were related to increased ratings or more positive ratings of private and public regard (Settles et al., 2010). This relationship remained when both public regard and private regard were observed independently with depressive symptoms (Settles et al., 2010). Settles and fellows' findings were unable to determine any predictive data concerning how depressive symptoms contributed to the African American women's ratings of private regard and public regard towards their self-perceptions of the African American race. This implies that the researchers could not determine if the sample's perception of how they view their race and/or how the women perceived society's perception of their race was a prediction of depressive symptoms. The study also revealed that African Americans with positive private regard and a strong racial identity (or centrality) reported fewer depressive symptoms (Settles et al., 2010). Lastly, Settles and fellows expressed that there was a strong mediating effect among increased private regard and increased self-esteem perceptions which further contributed to the sample of African Americans reporting lower rates of depressive symptoms.

### **Shame and Guilt**

Research has found that shame appears to be related to depressive symptoms (Orth, Berking, & Burkhardt, 2006; Tangney, Wagner, Fletcher, & Gramzow, 1992), which may be due to the effects shame has on individual's criticizing him/herself negatively (Orth et al., 2006; Tangney & Dearing, 2002; Tangney et al., 1992). A study done by Orth et al. (2006) looked at how rumination of negative self-criticism affects

shame and depressive symptomology. The researchers hypothesized that shame contributed to the mediating effects of depressive symptoms through means of rumination or persistent stewing of negative internalized messages about one's self. Additionally, the researchers aimed to find alternative ways to measure the concept of rumination, they sought to support other research findings which previously identified that guilt emotions were not associated with depressive symptoms, and they attempted to utilize the structural equation model (SEM) in order to differentiate shame rumination from guilt rumination (Orth et al., 2006).

Orth and colleagues (2006) sample included 149 men and women from regions around Switzerland, who were divorced parents and whose ages ranged from 25 to 69 years old. The researchers developed a shame and guilt measure entitled, Event-Related Shame and Guilt in which the measure consisted of 12 questions that addressed the participants' contextual frame of reference (i.e., the questions focused on shame and guilt in response to the sample's current relationship status). Participants also completed the Impact of Event Scale-Revised (IES-R) which examined rumination in reference to life stressors, and the Center of Epidemiology Scale (CES-D) which was used to measure participants' depressive symptoms (Orth et al., 2006).

Orth and fellows (2006) study confirmed that guilt and shame emotions were related to depressive symptoms and that when guilt emotions were controlled for, only shame emotions was associated with depressive symptoms. The study was able to support their hypothesis that shame based rumination contributed to shame's association with depressive symptoms (Orth et al., 2006). The researchers stated that they were able to statistically separate guilt and shame emotions as two independent constructs, and that

the study was able to demonstrate that there is some form of causal relationship between shame emotions, depressive symptoms, and rumination. Furthermore, this study's findings added validity to the idea that rumination plays a role in contributing to depressive symptoms and that shame emotions, due to the internalizing nature of shame, may also contribute to the rumination process (Orth et al., 2006).

Orth and colleagues (2006) explained that their results may be generalizable to the population they sampled but requires more investigation to ensure generalizability across other groups. Their sample contained individuals who were from a non-clinical population and thus the researchers stressed that more information is needed in order to understand how their findings would appear among clinical groups or with those from diverse backgrounds (Orth et al., 2006).

Next, the goal of Andrews, Qian, and Valentine 's (2002) research was to develop the Experience of Shame Scale (ESS) in order to determine if the construct of shame was a predictor of depressive symptoms and/or to further rule out the possibility that shame interviews contribute to reports of shame. The researcher's sample included 163 male and female participants between the ages of 19 and 48 years old. No information regarding race/ethnicity and SES was provided. Andrew and colleagues administered the ESS, which was composed of 25 questions that measured levels of shame emotions by assessing for behavioral response and internalized feelings associated with shame, and , by assessing the participants' responses in pragmatic situations (i.e., the individuals own perceptions about his/her behaviors). The ESS was comprised of eight categories which could manifest in daily activities (i.e., displaying shameful emotions through behaviors and feelings such as having negative views about one's appearances and attempting to

hide aspects of one's appearances; Andrew et al., 2002). The Test of Self-Conscious Affect (TOSCA) was used to test the accuracy of the ESS measurement (Andrew et al., 2002). The TOSCA consisted of 15 daily life circumstance and five subscales (i.e. shame proneness, detachment, pride, guilt proneness, and externalization of the event), but Andrews and colleagues stressed that their study only compared the guilt proneness and shame proneness subscales to their ESS measurement. The researchers used the Symptom Checklist-90 (SCL-90) to measure depressive symptoms and to further compare the ESS's ability to accurately assess for depressive symptoms as well. The SCL-90 consisted of a total of 10 questions for its depressive symptoms subscale, in which the participants were able to rate their symptoms along a continuum as either being absent to being exceptionally prevalent (Andrew et al., 2002).

Andrew and colleagues' (2002) results yielded that depressive symptoms and shame emotions shared a prominent correlation with each other in which shame emotions were associated to depressive symptoms, and that shame emotions may provide information about the beginning of a depressive episode. The researchers found that the ESS measure appeared to assess more instances of experienced shame and that the ESS was congruent with the TOSCA measurement's relationship among shame proneness and depressive symptoms. This relationship was also noted in the ESS and TOSCA's assessment of contextual shame proneness and shame about one's appearance (Andrew et al., 2002). Lastly, as a result of Andrew and fellow's (2002) study being comprised of different levels and distinct categories of shame proneness, the researchers concluded that the shame construct may consist of different components (i.e., behavioral attributes, situational components, etc.) that are interrelated with each other.

## **Shame and Guilt in Black Women**

To date, Ehrmin's (2001) ethnography study concerning African American substance abusing mothers, has been one of the only studies conducted which attempted to understand the cultural relevance guilt emotions and shame emotions has within the African American female population. Ehrmin's study focused solely on African American women and how various factors contributed to their self-perception of motherhood. The qualitative study consisted of 30 participants in which 12 women were denoted as "key" participants (i.e., women who received detailed information concerning the study) who were interviewed eight times, while the remaining 18 women were denoted as "general" volunteers (i.e., women who received basic information concerning the study) who were interviewed twice (Ehrmin, 2001). Each of the 30 participants were African American females who were residents of a substance abuse center, and were between the ages of 23 to 44 years old (Ehrmin, 2001). Ehrmin (2001) explained that the women were all interviewed about their past experiences with substance abuse (i.e., child-rearing while addicted to substances) and their current efforts to maintain a sober lifestyle (i.e., their present experiences with coping with guilt and shame emotions).

The qualitative study highlighted that persistent feelings of guilt and shame were mentioned throughout the interviews in reference to their self-evaluations as a parent (Ehrmin, 2001). Moreover, shame and guilt themes emerged from all of the 12 "key" volunteers' interviews in which their continual feelings of shame and guilt about their past substance abuse influenced how they coped or reconciled with family members, especially their children (Ehrmin, 2001). Ehrmin suggested that persistent or untreated feelings of guilt and shame may prevent or cripple African American women from

performing in a healthy manner consistent with their cultural norms (i.e., being a stable caregiver, carrying on the family traditions, etc.). African American women play a critical role in securing the survival of the family, and if untreated guilt and/or shame emotions prevent a women from participating in her cultural norms, this may be increasingly detrimental for the woman as well as her family (Ehrmin, 2001). Lastly, Ehrmin (2001) explained that assisting African American women who have untreated feelings of guilt and shame may allow them to become more successful during the rehabilitation process.

A 1998, study by Lutwak, Razzino, and Ferrari examined shame and guilt proneness in a sample of African Americans, White Americans, Asian Americans, and Latin Americans. The premise of their study was to identify whether or not shame proneness was related to concerns of intimacy and fraudulence in a diverse sample. The researchers also desired to develop an understanding of how shame proneness would appear in different racial and ethnic groups. Their sample consisted of 43 African Americans, 38 White Americans, 66 Asian Americans, and 44 Latin Americans; moreover, there were 66 females and 122 males who were between the ages of 17 to 34 years old (Lutwak et al., 1998).

The TOSCA measurement was used to determine participant's rates of shame and guilt proneness, while the Fear of Intimacy Scale (FIS) which was comprised of 35 questions, which was used to assess anxiety and other concerns regarding inadequacies in intimacy (i.e., difficulties maintain trust; Lutwak et al., 1998). Additionally, the Perceived Fraudulence Scale (PSI) allowed the participants to report their perceived level of self-criticism (i.e., having negative thoughts about their accomplishments, or thoughts



of self-deprecation) and perceived genuineness (i.e., not feeling genuine about one's self, or feelings of inauthenticity; Lutwak et al., 1998).

Lutwak and fellows' (1998), findings illustrated several interesting conclusions. First, shame proneness was significantly related to more negative attributes (i.e., inadequacies about intimacy) in comparison to guilt proneness; thus, guilt proneness was not significantly related to any of the participants self-reports on the FIS and PSI (Lutwak et al., 1998). Secondly, the findings revealed that shame proneness was associated with reports of inauthenticity and self-deprecating perceptions for all ethnic groups except Asian Americans who experienced greater levels of shame proneness in comparison to their counterparts (Lutwak et al., 1998). Thirdly, Lutwak et al., found that different ethnicities may have a different internalization of shame proneness which contributes to how one group will perceive the effects of shame. For instance, the results indicated that levels of shame for White Americans and Asian Americans could be predicted by levels of self-deprecation, whereas among the African American comparison group shame proneness could be predicted by worry and trepidation of being in an intimate relationship. Additionally, across all ethnic groups there was an association between shame proneness and reports of self-criticism and feelings of inauthenticity (Lutwak et al., 1998). Lastly, the study suggested that shame proneness may have a significant relationship with internalization of social constructs and self-perceptions, which may further contribute to shame proneness' relationship to self-criticism and self-genuineness (Lutwak et al., 1998).

## **Research Questions**

The objective of the study was to expand our understanding about the relationships between the constructs of shame proneness, guilt proneness, and depressive symptoms in a sample of Black women. Several questions were answered from the study:

1) Did Black women's reports of shame proneness significantly relate to reports of depressive symptoms? 2) Did Black women's reports of guilt proneness significantly relate to reports of depressive symptoms?

### **Hypotheses**

The hypotheses for this study were as follows: 1) shame proneness on the TOSCA-3 measurement will be positively and significantly related to higher levels of depressive symptoms on the DASS-21; 2) Guilt proneness on the TOSCA-3 measurement will be positively and significantly related to higher levels of depressive symptoms on the DASS-21 measurement.

## CHAPTER II

### METHODOLOGY

#### **Procedure**

The researcher emailed and/or contacted the following organizations by phone or email and provided them with general information concerning the objective of the study. The subjects were recruited using the snowball technique in which list-serves were derived from the American Counseling Association (ACA) e-mail list, the Association for Behavioral Cognitive Therapies (ABCT) e-mail list, and social networking sites (i.e. Facebook). To begin the snowball approach subjects were recruited by contacting churches within the Tulsa, OK, Oklahoma City, OK, Houston, TX, and Chicago, IL areas. The researcher also solicited participation from community centers within the Tulsa, OK and Oklahoma City, OK areas, and from the Langston-Tulsa University campus in Tulsa, OK. The researcher inquired if members of churches and community centers would feel comfortable with emailing the URL FrontPage link of the on-line surveys to other members within his/her designated community who met the study's requirements. Women who opted to participate in the study were asked to voluntarily email the link to other women as well. Requirements for this specific study included collecting data from women between the ages of 18-70 years of age, who identified their sex/gender as female, and who identified themselves as being African descent.

Organizations, who were a part of the list-serve, emailed the researcher a brief statement that indicated that they agreed to be placed on the list-serve. Once the researcher received an email from these groups confirming that they agreed to participate in the snowball approach, the researcher then forwarded the URL link containing the contents of the study.

Also, study participants who received the link had the ability to indicate whether or not they would like to participate and thus agree to the terms of the informed consent of the study by selecting either “accept participation” or “decline participation.” After the participants agreed to participate, they were then directed to the online survey in order to complete the questionnaires.

The online survey was password protected and the information gathered from the survey was only accessible by the researcher and co-investigator. No identifying information was collected. Lastly the researcher’s email address was available if any of the participants or other members on the list-serve had any questions or technical difficulties.

## **Measures**

### **The Depression Anxiety Stress Scale 21 (DASS-21; Lovibond & Lovibond, 1995).**

The DASS-21 is a 21-item scale measuring features of “depression, hyper-arousal and tension in clinical and non-clinical groups” (Antony, Beiling, Cox, Enns, & Swinson, 1998, p. 181). The current DASS-21 is a shortened version of the original 42-item DASS (Lovibond & Lovibond, 1993). Participants were required to read each of the 21 responses and then rated the extent to which they experienced each symptom over the last

week, using a four-point Likert scale (0=did not apply to me at all; 1=applied to me some of the time; 2=applied to me a good part of the time; 3=applied to me most of the time).

The depressive symptoms subscale was intended to measure feelings often associated with dysphoric moods such as worthlessness or sadness. The anxiety subscale measured symptoms such as trembling or faintness that are often related to states of physical arousal, panic attacks, and fear. Furthermore, the stress subscale measured overreaction to stressful events, irritability, and tension.

In order to determine an individual's true score on the DASS-21 subscales, it was required that the sum of the subscale be multiplied by two, then compared to the cut-off scores to identify the participants' levels of symptoms (Henry & Crawford, 2005; Lovibond & Lovibond, 1995). The following are the cut-off scores for the depressive symptoms subscale: scores ranging from 0 to 9 represented normal or minimal depressive symptoms, 10 to 13 indicated mild symptoms, 14 to 20 indicated moderate symptoms, 21 to 27 represented severe or high symptoms, and scores higher than 28 were signs of extremely high or extremely severe symptoms. The cut-off scores on the anxiety subscale included: scores ranging from 0 to 7 were normal or minimal symptoms of anxiety, mild symptoms were represented by scores of 8 to 9, moderate symptom scores ranged from 10 to 14, severe or high symptoms ranged from 15 to 19, and extremely high or extremely severe symptoms included scores higher than 20. Lastly, the cut-off scores from the stress subscale included: minimal or normal symptoms were between the scores of 0 to 14, mild symptoms ranged from 15 to 18, 19-25 indicated moderate symptoms, severe or high symptoms ranged from 26-33, and extremely high or extremely severe

symptoms included scores of 34 or more. For the purposes of this study only the depressive symptoms subscale was used.

The internal consistency reliability coefficients for the overall scale as well as the depressive symptoms, anxiety symptoms, and stress symptoms subscales were .93, .90, .77, and .88 respectively (Lovibond & Lovibond, 1995; Henry & Crawford, 2005). The current study indicated that the depressive symptoms subscale had significant reliability with Cronbach's alpha at .872 within the present sample of Black women, respectively. Additionally, the DASS-21 had good convergent validity with the Beck Depression Inventory (BDI), the Beck Anxiety Inventory (BAI) and the State-Trait Anxiety Inventory-Trait version (STAI-T; Lovibond & Lovibond, 1995; Henry & Crawford, 2005).

**TOSCA-3 (Test of Self-Conscious Affect-3; Tangney, Dearing, Wagner, & Gramzow, 2000).** The TOSCA-3 is the revised version of the original TOSCA form (Tangney et al., 2000). The purpose of this measurement was to provide a self-report method of measuring shame proneness and guilt proneness through scenario-based means. Examining scenario-based reports allowed a more defined distinction between shame proneness and guilt proneness (Rusch, Corrigan, Bohus, Jacob, Brueck, & Lieb, 2007; Tangney et al., 2000). Tangney and colleagues (2000) explained that TOSCA-3 included 16 questions that measured the constructs of shame proneness, guilt proneness, Alpha Pride, Beta Pride, externalization, and detachment (Rusch et al., 2007). The TOSCA-3 questions were described as:

Allowing the individual to select a response that reflects their shame proneness (“You would think, I am irresponsible and incompetent”); guilt proneness (“You would vow to be more careful next time”); externalization, or using external reasoning for why the event occurred (“You would think your friend must not take very good care of the dog or it wouldn’t have run away”); Beta Pride or pride in one’s actions/responses (“You would feel great that you had helped others”); Alpha Pride or self pride, “You would feel very satisfied with yourself; and detachment, or not being concerned about the event(“Life is unfair”). (Tangney & Dearing, 2002, pp.207-240)

The TOSCA-3 was comprised of 11 negative and 5 positive events that are aimed to be a reflection of everyday circumstances (i.e., outings with friends), in which the participants were required to respond to all four reactions listed in accordance with the scenarios (Rusch et al., 2007; Tangney et al., 2000). Next, the participants were required to rate his/her likely reaction towards each of the events on a likert scale of 1 (not likely) to 5 (very likely; Tangney et al., 2000). The TOSCA-3 assessment does not have prescribed cut-off scores but, rather the scores on each subscales may be used to determine if one form of proneness is more or just as equivalent than an opposing proneness (Tangney & Dearing, 2002). The measure received a Cronbach’s alpha of 0.77 - .088 for reliability for the shame proneness construct and a Cronbach’s alpha of 0.70 - 0.83 for the guilt proneness constructs.

The present study demonstrated that the TOSCA-3 shame proneness subscale had significant reliability with a Cronbach’s alpha of .833 for the 16 item subscale, and the guilt proneness subscale had moderately significant reliability with a Cronbach’s alpha of .695 within the sample of Black women, respectively (Table 2, Appendix A). The previous

TOSCA scale was normed on a healthy population in which levels of shame proneness were correlated to symptoms of emotional disorders (i.e., depression, anxiety, etc; Stromsten, Henningsson, Holm, & Sunbom, 2009). Mullins-Nelson, Salekin, and Leistico (2006) noted that the TOSCA-3 had significant convergent validity to the BDI-II. On the contrary, Stromsten and fellows explained that TOSCA-3's scenarios are not entirely generalizable to diverse experiences and therefore, may not be inclusive of other groups (i.e., individuals who are differently abled or who have severe mental health disorders). Tangney and Dearing (2002) noted that they attempted to present the items on the TOSCA-3 in a gender neutral manner in order to lessen any unintentionally bias towards women. In addition, Tangney and Dearing wrote that the TOSCA-3 was normed on a diverse sample of college students (i.e. such as age, SES, race, etc). Nevertheless, the researchers did not provide any other specific details as far as how many individuals were represented in the diverse group or the descriptive make-up of the different groups. The current researcher did not find any studies that actually reported on the reliability and validity of this measure being used on Black American women participants.

**Demographic Form.** A demographic sheet was used to record the race/ethnicity, skin tone, body mass index, gender/sex, sexual orientation, income, age, and level of current education status of the Black women.



## CHAPTER III

### RESULTS

The original sample included 65 participants but a total of 13 participants were removed from the current dataset due to having more than 10% of their surveys incomplete. This was done due to the small sample size of Black women and in efforts to reduce error in the data analysis (Kline, 2005). As a result the current dataset included 52 participants in total; however, some of the unanswered items of the subscales were not included in the analyses. Thereby, the number of participants for each subscale measurement and for some of the demographic responses may demonstrate a *n* or total sample number to be somewhat lower than 52 (i.e., the TOSCA-3 shame proneness subscale included 47 completed responses, the TOSCA-3 guilt proneness subscale included 48 completed responses, and the DASS-21 depressive symptoms subscale included 45 completed responses).

#### **Demographic Data**

As seen in Table 3, Appendix A, among this sample of 52 Black women, the mean age was 33.40, with a range of 19 to 55 years old ( $n = 52$ ). A total of 45 women reported being Black non-Hispanic/non-Latina ( $n = 45$ ,  $M = 1$ ); 7 women did not report whether or not they were Black non-Hispanic/non-Latina or Black Hispanic/Latina, but did self-report themselves as being Black/African American, these women were included in the overall sample of 52 participants. Approximately 47 women self-identified as

heterosexual, 1 woman self-identified as lesbian/gay, and 4 women self-identified as bisexual ( $n = 52$ ). Thirty women self-reported that they were single, 14 women self-reported that they were married, 2 women self-reported that they were in a partnered/common law relationship, and 6 women self-reported themselves as being divorced ( $n = 52$ ). As a sample, the median education level was having a college degree ( $n = 52$ ; see Table 3, Appendix A). Also, within this sample, the median income level of the women was \$30,001-\$40,000 ( $n = 51$ ; Table 3, Appendix A). A total of 14 women reported their skin tone as fawn/light brown skin complexion, 27 women reported their skin tone as mahogany/medium brown skin complexion, and 11 women reported their skin tone as dark-chocolate/dark brown skin complexion ( $n = 52$ ). The BMI of the sample were calculated from the women's self-reported weight ( $n = 48$ ,  $M = 198.99$ ) and height ( $n = 50$ ,  $M = 65.75$ in or 5.47ft). The women who did not report either their height or weight were excluded from receiving a BMI score. Overall 2 participants did not report their height (1 of the 2 participants did not report either their height or weight) and 4 women did not report their weight, thus 5 women in total did not received a BMI score. Therefore, 47 women received BMI scores which indicated the following: 3 participants had scores of 18.50 or lower which was representative of being underweight, 7 women received a BMI between 18.50-24.90 which is representative of being in the normal/healthy category, and 37 women received a BMI score of 30.0 or higher which is indicative of being overweight or in the obese range ( $n = 47$ ,  $M = 32.68$ ,  $SD = 10.42$ ; Kowalsk & Yoder-Wise, 2007).

### **Descriptive Data of Subscales**

The TOSCA-3 assessment consisted of 16 questions for both guilt and shame, respectively. As seen in Table 1, Appendix A, the overall mean for the TOSCA-3 shame subscale was 38.02 ( $M = 38.02$ ,  $SE = .55$ ,  $SD = 11.63$ ), with a minimum score of 19.00 and a maximum score of 68.00 among the 49 respondents ( $n = 49$ ); 3 participants had incomplete responses. The overall internal consistency for the TOSCA-3 shame subscale had Cronbach's alpha of .833 for the 16 item subscale for the current sample of Black women (Table 2, Appendix A). In comparison, Tangney and Dearing (2002) demonstrated that the mean score for the TOSCA-3 shame proneness subscale for three different samples of participants to include: 1) 44.93 ( $SD=11.32$ ) for a sample of 142 women 2) 45.49 ( $SD=9.49$ ) for a sample of 275 women 3) 48.33 ( $SD=9.32$ ) for a sample 217 of women respectively. The reliability scores for the following three sampling groups were: 1) .88 (Cronbach's alpha) 2) .76 (Cronbach's alpha), and 3) .77 (Cronbach's alpha; 2002), respectively. It is difficult to generalize the current sample's results to Tangney and Dearing's (2002) findings as they did not specify the racial identity of their sample for the shame-proneness subscale but rather, the researchers explained that their sample consisted of a diverse body of individuals, thereby it is unknown if any of the norming sample for the TOSCA-3 shame proneness subscale included Black women.

Among this current sample however, the overall mean for the TOSCA-3 guilt subscale was 61.45 ( $M = 61.45$ ,  $SD = 7.72$ ,  $SE=1.11$ ), with a minimum score of 43.00 and a maximum score of 78.00 respectively ( $n = 48$ ). The overall reliability for the TOSCA-3 guilt subscale was .695 for the 16 item subscale (Cronbach's alpha was moderately reliable at .695, respectively; Table 2, Appendix A). As mentioned

previously, the TOSCA-3 measure does not have designated cut-off scores; instead it is suggested that the average scores on the subscales be compared in order to determine if a specific proneness is more prevalent than another. In comparison, Tangney and Dearing (2002) demonstrated that the mean score for the TOSCA-3 guilt proneness subscale from three different samples of participants reflect: 1) 63.43 ( $SD = 7.51$ ) for a sample of 142 women; 2) 64.09 ( $SD = 6.54$ ) for a sample of 275 women; and 3) 65.43 ( $SD = 7.54$ ) for a sample 217 of women, respectively. The reliability scores for these three sampling groups were: 1) .83 (Cronbach's alpha; 2) .70 (Cronbach's alpha); and 3) .78 (Cronbach's alpha; 2002), respectively. As mentioned previously, Tangney and Dearing (2002) did not report the actual race/ethnicity of their sample for the guilt-proneness subscale but rather, the researchers expressed that their sample included diverse individuals, once again, it is unknown whether or not the TOSCA-3 guilt proneness subscale was normed on a sample containing Black women.

The DASS-21 measurement included 7 questions which comprised the depressive .symptoms subscale. The overall mean for the DASS-21 depressive symptoms subscale was 4.48 ( $M = 4.48$ ,  $SD = 3.88$ ,  $SE=.55$ ), with the minimum score of 0 and a maximum score of 15, respectively ( $n = 45$ ). According to the cut-off scores of the DASS-21 measure, the average raw score of the sample was 4.48 ( 4.48 raw score x 2 = true score 8.96), which indicated that as a sample the Black women's average score on the depressive symptoms subscale was in the normal range of depressive symptomology. Additionally, the minimum score of 0 (0 raw score x 2 = true score 0) demonstrated normal or minimum depressive symptoms and the maximum score of 15 (15 raw score x 2 = true score 30) indicated severe or high depressive symptoms. The reliability for the

DASS-21 depressive symptoms subscale within the current sample was at Cronbach's  $\alpha = .872$ , respectively (Table 2, Appendix A).

### **Analysis of Data**

In order to address the study's hypotheses a Pearson's product moment correlations were conducted to 1) determine if the sample's report of shame proneness on the TOSCA-3 shame subscale was positively or negatively related to their self-reports of depressive symptoms on the DASS-21 depressive symptoms subscale; 2) to determine if the sample's reports of guilt proneness on the TOSCA-3 guilt subscale positively or negatively related to their self-reports of depressive symptoms on the DASS-21 depressive symptoms subscale. The results of the Pearson's analyses demonstrated that shame proneness was significantly positively correlated with depressive symptoms at [ $r = .465$   $n = 46$ ,  $p < .01$ ] (Table 1, Appendix A). Guilt proneness exhibited a positive directional relationship with depressive symptoms, however it was not significantly correlated at [ $r = .095$   $n = 45$ ,  $p < .267$ ] (Table 1, Appendix A).

## CHAPTER IV

### DISCUSSION

The current study sought to identify relationships among guilt proneness and shame proneness to depressive symptoms in Black women. Examining the relationships of guilt proneness and shame proneness to depressive symptoms may provide a different outlook in addressing depressive symptoms in Black women, which is warranted given the lack of mental health related research concerning women of African American heritage (Baker, 2001; Jones & Shorter-Gooden, 2003; Shorter-Gooden, 2009).

#### **Shame**

The results found in this study provided evidence that Black women's self reports of shame proneness do share a positive significant relationship with reports of depressive symptoms. This implies that within the current sample of Black women, their reports of depressive symptoms are related to their reports of shame proneness. The study's finding was also similar to Andrew and fellow's (2002), and Orth and colleagues' (2006) studies in which the researchers demonstrated that shame proneness is related to depressive symptoms. Among this small sampling of Black women, the mean score on the TOSCA-3 shame proneness subscale was 38.02 and the mean score for the TOSCA-3 guilt

proneness subscale was 61.45; however, shame proneness rather than guilt proneness demonstrated a positive and significant correlation to reports of depressive symptoms on the DASS-21 assessment. Additionally, this sample of Black women reported minimal to normal levels of depressive symptoms on the DASS-21 depressive symptom subscale. This may imply that this particular depressive symptom subscale may not be fully capturing depressive symptoms from the present sample of Black women, but rather the shame proneness subscale may be more reflective of how Black women experience distress. In other words, what we typically think of as depressive symptoms as measured by the DASS-21, are being captured by the shame proneness subscale. Therefore, it may be helpful to have a clearer understanding that for Black women, shame proneness, may be a worthwhile construct to explore with Black women who report symptoms traditionally related to depression.

As mentioned previously Black women tend to have higher reports of depressive symptoms in comparison to women of other racial groups (Dwight-Johnson, Unutzer, Sherbourne, Tang, & Wells, 2001; Etowa, Keddy, Egbeyemi, & Eghan, 2007; Jones & Shorter-Gooden, 2003; Shorter-Gooden, 2009). This factor may be exacerbated due to the lack of research and awareness concerning proper diagnosis, inaccurate diagnosis, and under-diagnosis for individuals of African American heritage (Baker, 2001; D. R. Brown, Ahmed, Gary, & Milburn, 1995; Jones & Shorter-Gooden, 2003). Therefore, it is critical to gain an understanding of how depressive disorders and depressive symptoms are manifested within this population, especially since previous research findings have suggested that some Black Americans experience depressive symptoms in way that is sociohistorical and culturally relevant (Baker, 2001; D. R. Brown, et al., 1995; Jones &

Shorter-Gooden, 2003; Romero, 2000; Settles, Navarrete, Pagano, Abdou, & Sidanius; West, 1995; West, Chrisler, Golden, & Rozee, 2008).

The average Black woman in this study was an obese single woman, in her early thirties, of medium brown/mahogany skin tone, with at least an undergraduate college degree, and an income between \$30,001 and \$40,000. Thus, it could be possible that this sample of Black women may experience feelings related to shame proneness as being more relevant to their current circumstances in life. In other words do these Black women feel instances of shame proneness and depressive symptoms because they find it difficult to maintain the various demands within their life and/or culture (i.e., being the source of social support, ensuring the success of the family/kinship, etc.); or perhaps, given their education and income do they feel shame and depression related to their success in comparison to others in their family/kinship or are these feelings more closely related to being obese in a society where the majority culture values thinness, or a combination of both?

Black women occasionally underreport symptoms of depression. Several factors, such as not wanting to appear as an inadequate source of support to their family, feeling as though some symptoms of depression are not culturally appropriate, or holding biases such as the counselor/therapist may not be attuned to the client's culture and would not understand, may influence underreporting (Brown, et al., 1995; Etowa, et al., 2007; Jones and Shorter-Gooden, 2003; Romero, 2000; Shorter-Gooden, 2009; West, 2008).

Therefore, it could be posited that the present sample of Black women, whom on average are single, have a college degree, have an income between \$30,001 and \$40,000, and have a BMI in the overweight range, may be attempting to underreport symptoms



typically related to depression in an effort to maintain the appearance of being a stable individual not affected by the stressors of their culture or by oppressive encounters in society at large (i.e., racism, sexism, etc). The notion of maintaining an appearance of stability coincides with the research findings and literature reviews of Etowa (2007), Jones and Shorter-Gooden (2003), Romero (2000), Shorter-Gooden (2009), and West (1995).

## **Guilt**

In this small sampling there were no significant correlations between Black women's reports of guilt proneness to their reports of depressive symptoms. While not significant, there was a positive directional relationship between the two variables, (Graph 2, Appendix A). This may suggest that feelings of guilt may not be as salient in comparison to feelings of shame as guilt may not necessarily cause an individual to negatively evaluate themselves internally (Bybee & Zigler, 1996). For instance, some of the items on the TOSCA-3 guilt proneness subscale may have placed a greater inference on the external environment instead of self-criticism (i.e., shame). Black women might rate such items higher to indicate that a particular event has no bearing on their internalized self-perceptions. If the participant felt guiltier about a particular scenario, this could be an indication that the event was not viewed as detrimental to their internal self and/or that the event did not affect their feelings of self-worth.

The findings of the current study were consistent with past studies, in which guilt was not significantly associated with depressive symptoms (Andrews, et al., 2002; Orth, et al., 2006). According to Orth et al. (2006), and Settles et al. (2010), guilt was not

associated with rumination or negative self-evaluation in reference to depressive symptoms. Unlike shame, guilt may be defined as an attribute that evokes negative criticism on the external environment or society around the individual; whereby shame is an internalization of negative self-criticism (Rusch, et al., 2007; Tangney & Dearing, 2002).

As mentioned throughout the study, the African American culture views women as significant pillars within their family, community, and or kinship, due to their primary role of securing the success of their family and maintenance of cultural traditions and mores (Baker, 2001; Ehrmin, 2001; Etowa, et al., 2007; Jones & Shorter-Gooden, 2003; Romero, 2000; Shorter-Gooden, 2009; West, 1995; West, et al., 2008). As a result of this massive and critical role Black women have, it is traditionally expected of her to refrain from displaying stereotypically feminine emotions (i.e. crying, displays of sadness, etc.) because she serves as the source of social support, and thus must keep the appearance of stability or strength (Jones & Shorter-Gooden, 2003; Romero, 2000; West, 1995).

Additionally, since depression entails an individual being consumed with his/her own emotional struggles, engaging in typical depressive symptoms (increased sadness, anhedonia, loneliness, etc.) may be viewed as a selfish attribute within the African American culture (Jones & Shorter-Gooden, 2003; Shorter-Gooden, 2009), and thereby be incongruent with their cultural values and mores. Going against one's cultural standards has the possibility of being mentally crippling and problematic, in which an individual may endure intense negative self evaluations or self-criticism. This factor may provide some understanding to guilt's non-significant relationship with depressive symptoms within the current sample of Black women but further investigation is

warranted in efforts to accurately identify any mediating and causal effects guilt proneness may have on depressive symptoms within a sample of Black women.

## **Implications**

The present study contributes to research and literature by being one of the first studies that empirically examined the relationships of shame proneness, guilt proneness, and depressive symptoms within a sample of Black women. Finding a positive significant relationship among shame proneness and depressive symptoms, and a positive directional association with guilt proneness and depressive symptoms, may enhance our understanding depressive symptoms within samples of Black women.

The results of the study indicate that shame proneness, but not guilt proneness, is a noteworthy construct that shares a positive association to depressive symptomology among a sample of Black women. Based on the findings, clinicians may attempt to assess for shame proneness attributes, and other instances of negative internalized messages. For example, if a clinician's African American female client is expressing more behavioral and overt symptoms of psychological distress (i.e., decreased sleep, increased eating behaviors, increase health problems) rather than covert or emotional symptoms (i.e., flat affect, or increased sadness), it may be beneficial to the client for the clinician to ask questions related to shame proneness.

Previous studies have cautioned that Black women have higher rates of depressive symptoms than other ethnic/racial groups and are more likely to be misdiagnosed, under-diagnosed, or find therapy unhelpful due to clinician bias (Baker, 2001; Jones & Shorter-Gooden, 2003; Romero, 2000; Shorter-Gooden, 2009). Given that there are a lot of

unknown attributes to how Black women may experience depressive symptoms, further investigation is warranted about how to accurately capture symptoms of depression among samples of Black women.

### **Limitations**

The present study encountered several limitations. First, the sample size of the study could have affected the results and findings. The study consisted of only 52 participants, if the sample size consisted of a greater number of Black women, then any association among the variables could possibly produced stronger relationships within this sample.

Also, the measures used in the study may not have been as culturally sound as other means of assessing for shame proneness, guilt proneness, and depressive symptoms. As was mentioned, the TOSCA-3 measurement by Tangney and Dearing (2002) did not specify whether not their measure was normed with any Black women among their sample. Using other means and assessments that have more cultural relevance to Black women could possibly provide additional and stronger information in regards of the relationship among shame proneness, guilt proneness, and depressive symptoms. .

Third, the sample was gathered through means of a snowball approach which could have limited certain members of the African American community from participating in the sample. The sample was derived from a social networking website (i.e., Facebook), emailing members of several professional organizations (i.e., American Counseling Association), and by contacting community and church members in Tulsa, Oklahoma, Oklahoma City, Oklahoma, Chicago, Illinois, and Houston, Texas areas. By

only targeting certain outlets to create a snowball approach, many individuals were inadvertently excluded from the study. For example, it is plausible certain members within the Black community who do not have access to computers or who do not participate within certain online social networks would not have the ability to participate in the current study. Unfortunately, this factor may have even excluded women from lower SES groups, women of older age whom may not be aware social networking websites, and women from other regions of the U.S.

Fourth, given the collective nature of the African American culture, this group's means of coping could be composed of different elements (such as spirituality, social support from the kinship, etc.) which may have affected the minimum or normal scores for the sample's average on the depressive symptom (DASS-21) measure. This is especially noteworthy since the study's sample was derived from local community centers and churches within the African American community.

Lastly, environmental factors could have affected the participants' response on the shame proneness, guilt proneness, and depressive symptoms subscales. For instance, the responses could have been affected by such variables as age discrimination, sexual orientation discrimination, SES, the stressors of being single, or stressors of being a caregiver (Ehrmin, 2001; Jones and Shorter-Gooden, 2003; Romero, 2000; Shorter-Gooden, 2009). Such variables could have possibly affected reports and levels on the shame proneness, guilt proneness, and depressive symptoms subscales. Furthermore, such environmental factors were not controlled for in the analyses of the current study.

### **Future Research**

The findings of the current study may provide a basis for looking at additional relationships shame proneness, guilt proneness, and depressive symptoms may have with other constructs within the African American community. Approximately 78.72% of the sample in this study had a BMI in the obese/overweight range ( $n = 47$ ). Also, approximately 26.92% of the women noted their complexion as fawn/light brown, 51.92% of the women indicated their complexion as mahogany/medium brown, and 21.15% of the women reported their complexion as dark-chocolate/dark brown ( $n = 52$ ). Looking at the relationships among skin tone and eating disturbances (such as binge eating behaviors) to shame proneness, guilt proneness, and depressive symptoms could provide additional information concerning how Black women may cope with shame, guilt or depressive symptoms (i.e., compensating with binge eating), how Black women's skin complexion may or may not influence emotional distress, and it could provide a better understanding of how certain maladaptive eating behaviors may be more culturally relevant to Black women.

Past research has shown a link between depressive disorders and/or depressive symptoms to the onset of a binge eating episode (Aime, Craig, Pepler, Jiang, & Connolly, 2008; Santos, Richards, & Bleckley, 2007; Sherry & Hall, 2009). This implies that depressive symptoms and disordered eating may occur simultaneously, and thereby it is expected that this same relationship will be illustrated within the current sample of Black women. As a result of the current study's findings, in which shame proneness exhibited a strong positive relationship with Black women's reports of depressive symptoms, future studies looking at other behaviors that have been associated with depressive symptoms may prove to be very valuable within this sample.

The results from a 1996, study by Bybee and colleagues showed that guilt about a specific situation (i.e., school) was related to ineffective coping behaviors and to reports of depressive symptoms. In the addition, the study found no significant relationship among ineffective guilt coping behaviors to disordered eating behaviors, and that guilt proneness did not demonstrate a relationship to eating disturbances. However, unresolved guilt feelings due to ineffective coping behaviors were associated with maladaptive eating behaviors. Lastly, Bybee and colleagues' study denoted that guilt personalities have no significant relationship to maladaptive eating behaviors and depressive symptoms.

It may be mentioned that Bybee et al., (1996) defined guilt as an internalization of self-blame; however, it may be argued that this definition of guilt is somewhat similar to that of shame (Tangney & Dearing, 2002). Thus, it may be worthwhile to examine shame proneness and depressive symptoms to disruptive eating behaviors. Moreover it is further expected to find relationships among binge eating behaviors to shame proneness, guilt proneness, and depressive symptoms when examining these concepts from a culturally relevant viewpoint.

Additionally, the emphasis of skin tone could play a very unique role within this sampling of Black women due to sociohistorical dynamics and stereotypes of skin complexion with the African American community. Women of African American decent have a unique history in which they had to possess both feminine and masculine qualities in order to properly support themselves, their families, and/or kinships (Bass, 2001; Jones & Shorter-Gooden, 2003; Shorter-Gooden, 2009; Woodard & Mastin, 2005). By taking on what may be considered more masculine roles, feelings of sadness may not be

‘acceptable’ for these Black women, just as they are not typically acceptable for men. In efforts to develop a more enhanced understanding of depressive symptoms, shame proneness, and guilt proneness within Black women, it is suggested that historical archetypes of Black women be examined. The following is a brief historical overview of three common historical stereotypes of African American women.

### **Mammy**

The visual image of the mammy can be depicted as an overweight Black woman, with a dark brown complexion, who is very sensitive to the needs of her White counterparts (Glenn & Cunningham, 2009; Henderson Daniel, 2000; Stephens & Phillips, 2003; West, 1995; Woodard & Mastin, 2005). However, the mammy is described as being extremely harsh towards her children, sexually undesirable, and having a questionable gender identity (West, 1995). The mammy’s gender is viewed as ambiguous because she is sexually a female but, due to her large stature, masculine and dominant personality she is oftentimes depicted as having the gender qualities similar to men (West, 1995; Woodard & Mastin, 2005). The illustrations of the mammy figure reflect a lot of internalization (i.e., shame or guilt) of unhealthy constructs such as an ambiguous sexuality, being consistently viewed as sexually undesirable, having inadequate parenting skills, and being subservient to White counterparts (Bass, 2001; Henderson Daniel, 2000; Glenn & Cunningham, 2009; Stephens & Phillips, 2003; West, 1995; Woodard & Mastin, 2005).

### **Sapphire**



The sapphire stereotype is similar to that of the mammy, in which she is described as having a masculine persona (often referred to in the negative connotation) who deliberately de-emasculates her male partner (Henderson Daniel, 2000; Shorter-Gooden, 2009; Stephens & Phillips, 2003; West, 1995). In some respects, the sapphire is visualized as a semi-masculine, heavily built woman (not necessarily overweight and/or obese), somewhat physically attractive, and strong-willed. Her skin tone is a balance between the mammy (dark brown) and jezebel (light brown) and she is characterized as possessing a very dominant personality (West, 1995). Similar to the mammy construct, the sapphire endures internal psychological distress (i.e., shame and/or guilt) due to individuals being intimidated by her personality (West, 1995).

### **Jezebel**

The Jezebel (or mysterious mullatto) can be described as a Black woman with very fair complexion with exotic or ambiguous racial features (Bass, 2001; West, 1995). For instance, the Jezebel's skin complexion will be similar to her White counterparts, her hair texture will not be as coarse as the mammy's or the sapphire's, and other facial and body portions will be identical to her White counterparts (Stephens & Phillips, 2003; West, 1995). Even though the jezebel may have similar features of the majority, her personality is depicted as being sexually deviant, and absent of morals and virtues (Glenn & Cunningham, 2009; Henderson Daniel, 2000; Shorter-Gooden, 2009; Stephens & Phillips, 2003). In addition, the Jezebel may not readily identify with other Black women because, she is viewed as the more physically desirable (or "correct") image of a woman from the majority culture's viewpoint.

In contrast to the previous two stereotypes, the jezebel may endure external (i.e., guilt) psychological distress that may be more affiliated with outside forces. For instance, the jezebel figure may endure great emotional distress due to her spiritual morality and race being questioned by the mainstream majority as well as by her own community (Glenn & Cunningham, 2009; Henderson Daniel, 2000; Shorter-Gooden, 2009; Stephens & Phillips, 2003). Unlike the mammy and sapphire images, the jezebel has the ability to attain more benefits and advancement in mainstream society due to her passing features (Bass, 2001; Goldsmith, 2001; Greene, et al., 2000).

Examining the sociohistorical archetypes of African American women could provide more enhanced and specific information about how instances of shame proneness, guilt proneness, and depressive symptoms may vary depending on how the women and or society view them. As indicated in the results section, data about skin tone and body mass index were collected from this sample of Black women. While this information was not the focus of this particular study, the data may be used in determining if women with certain skin tone complexions and body mass indexes will have higher rates of shame proneness, guilt proneness, and/or depressive symptoms in future studies.

## CHAPTER V

### LITEATURE REVIEW

#### **Sociohistorical Accounts**

Past literature and research has cautioned that Black Americans and especially Black women experience higher rates of depressive disorders and/or depressive symptoms in comparison to other racial/ethnic groups and even Black men (Cooper, Gonzales, Gallo, Rost, Meredith, Rubenstein, Wang, & Ford, 2003; Robins & Regiers, 1991; Shorter-Gooden, 2009). Likewise, Black women are more likely to be misdiagnosed, under diagnosed, misrepresented in research (i.e., limited research looking at the cultural significance of depressive symptoms) or receive inappropriate treatment for their mental health concerns (Baker, 2001; C. Brown, Schulberg, Sacco, Perel, & Houck, 1999; Brown, et al., 1995; Leo, Sherry, & Jones, 1998; Romero, 2000; West, 1995). In addition, research and historical accounts have concluded that women of African American heritage may have a tendency to express their depressive symptoms in ways contrary to mainstream symptoms (e.g., loneliness, increased sadness, etc.) which could possibly be contributing to the lack properly diagnosed treatment for Black women (Etowa, et al., 2007; Jones & Shorter-Gooden, 2003; Romero, 2000; Shorter-Gooden, 2009; West, 1995).

Equally important, women of African American heritage may tend to express emotions typically related to depressive symptoms in a manner that is culturally appropriate for them to maintain a sense of strength because, historically (and even today) Black women have customarily served as a source of survival for their family (Ehrmin, 2001; Louis, 2001; West, 1995; West et al., 2008). For Black women this entailed demonstrating both feminine traits (i.e., being a caregiver) and masculine traits (i.e., displaying emotional strength to endure racism and sexism; Jones & Shorter-Goode, 2003; Louis, 2001; Shorter-Gooden, 2009; West, 1995; West et al., 2008). Therefore, it may be plausible that women of African American heritage may report their depressive symptoms in a more culturally accepted manner such as indicating feelings of resentment or self blame rather than lost of interest in activities or sadness. In this respect, the present study examined shame proneness and guilt proneness in relationship to depressive symptoms because guilt and shame emotions offer alternative outlets of expressing depressive symptoms, such as internalized feelings of self-blame or worthlessness which may align more with African American culture (Jones & Shorter-Gooden, 2003; Romero, 2000; Shorter-Gooden, 2009; West, 1995; West et al., 2008).

Historically, Black women had no ownership of their bodies, but rather their bodies were the property of the slave owner (Peterson, 2001; Shorter-Gooden, 2009). Subsequently, after the Civil War and the ending of slavery, individuals of African descent were not defined as human until the 1868 14<sup>th</sup> amendment was enacted. Prior to this amendment, an underlying cultural notion in the U.S. at that time contributed to the idea that being considered an actual physical and spiritual human being was the sole privilege of White Americans (Peterson, 2001). Thus, the natural existence of Blacks as

a people was a privilege that they could not achieve due to their obvious biological and racial make-up. Being considered racially Black was equivalent to being considered abnormal or nonexistent in the human race; which may have lead to the notion that Black women's bodies are distinctly nontraditional and deviant (Bennett & Dickerson, 2001; Peterson, 2001).

Jackson (2000) wrote that during slavery African American women were placed in highly psychological and emotional distressing predicaments which still bear witness in modern times. Black female slaves had to maintain a way of survival and protection in the midst of racism, sexism, witnessing their children or partner being sold as commodities, and endure the mental toil of being classified as property. As a result, Jackson explained, Black women had to become completely self-sacrificing, selfless, and dominant figures within their family to promote the success of their family. Furthermore, the uniqueness of African American history and the complex role Black women had to maintain for purposes of survival, may have influenced this population to experience emotions and psychological distress in ways that are different from other ethnic groups.

### **Shame Proneness and Guilt Proneness**

Some studies have suggested that the constructs of guilt proneness and shame proneness may be more culturally appropriate means for Black women to convey emotions typically associated with depression (Jones & Shorter-Gooden, 2003; Romero, 2000). For instance, Romero (2000), and Pipes, McAdoo and Young (2009) found that Black women tend to feel more comfortable expressing that they have trouble balancing multiple roles (i.e., being the primary caregiver for their nuclear family and extended

family, enforcing cultural traditions, rearing children, etc.) and often feel guilty for not being able to juggle these multiple roles successfully. Thereby, when Black women feel incompetent in fulfilling their various roles, such feelings of inadequacy may lead to feelings of shame and/or guilt.

The DSM-IV-TR recognizes feelings of guilt and constant critical self evaluations (i.e., self-blame) as symptoms of depression. Black women may experience depressive symptoms but the manner in which they relay their feelings of depression may be expressed as feelings of guilt or shame. Expressing feelings of guilt and shame rather than as other forms of depressive symptoms may be considered more culturally appropriate given the dynamics of a Black woman's role (i.e., the woman maintaining a dominant position within the family; Romero, 2000).

The constructs of shame and guilt are sometimes used correspondently in everyday language (Tangney & Dearing, 2002; Piers & Singer, 1953). Shame can be noted as an individual's focus on his/her internal self, while guilt is a reflection on an individual's external environment (Rusch et al., 2007). Gilbert (1998) wrote that shame has the ability to affect various levels of human behaviors and cognitions. Thus, shameful thoughts and emotions may be observed via an individual's behaviors, interactions with others, and through other external environmental interactions (i.e., submission or concealment). This suggests that shame has the ability to filter through one's emotional state and manifest in various attributes of a particular individual.

Moreover, Piers and Singer (1953) inscribed that shame is a factor in social appropriateness, in which an individual's perception of themselves may be relevant in

efforts to “successfully” adhere to societal standards. This notion may be reinforced by past beliefs that Black female slaves were the property of their White owners and were considered “owned” by those of the majority culture (Lewis, 1993).

## **Depression**

The DSM-IV TR characterizes depression as:

An individual experiencing increased sadness, loss of interest, increased or decreased weight gain, an increase or decrease in sleep, change in psychomotor activity, increased feelings of worthlessness and shame /guilt, suicidal thoughts or ideations, and additional depressed behaviors (i.e., decreased concentration, somatic complaints, etc.). (American Psychiatric Association, 2000; p.349)

Depressive symptoms have also been attributed to negative health attributes, dysfunctional eating patterns and behaviors, low self-esteem, poor school performances, teenage pregnancy, and psychosocial difficulties (i.e., inability to maintain friendships; Grant, et al, 1999; Harrell & Jackson, 2008). Given that past research has shown that Black women have a tendency to underreport symptoms typically associated with depression (Etowa et al., 2007; Jones & Shorter-Gooden, 2003; Romero, 2000), this current study undertook the task of exploring any correlations between symptoms of depression and the constructs of shame proneness and guilt proneness.

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## APPENDICES

### APPENDIX A: TABLES AND CHARTS

Table 1: Mean of Total Shame Proneness Subscale and Total Guilt Proneness Subscale, and Partial Correlations with Total Depression Subscale

Subscales	N	1	2	3
1. Shame Proneness Subscale	47	38.02 (11.63)		
2. Guilt Proneness Subscale	48	.294*	61.45 (7.72)	
3. Depression Subscale	45	.465**	.095	4.48 (3.88)

\*\*, Correlation is significant at the 0.01 level (1-tailed). \*\*  $P < .01$

\*, Correlation is significant at the 0.05 level (1-tailed). \* $P < .05$

The means of the subscales and variances are listed on the first diagonal line

Table 2: Reliability Scores for TOSCA-3 Shame Proneness, TOSCA-3 Guilt Proneness, and DASS-21 Depression Subscales in a Sample of Black Women

Subscales	N	Number of Questions	Reliability
Shame Proneness Subscale	49	16	.833
Guilt Proneness Subscale	48	16	.695
Depression Subscale	49	7	.872

Reliability was set at 95% confidence interval

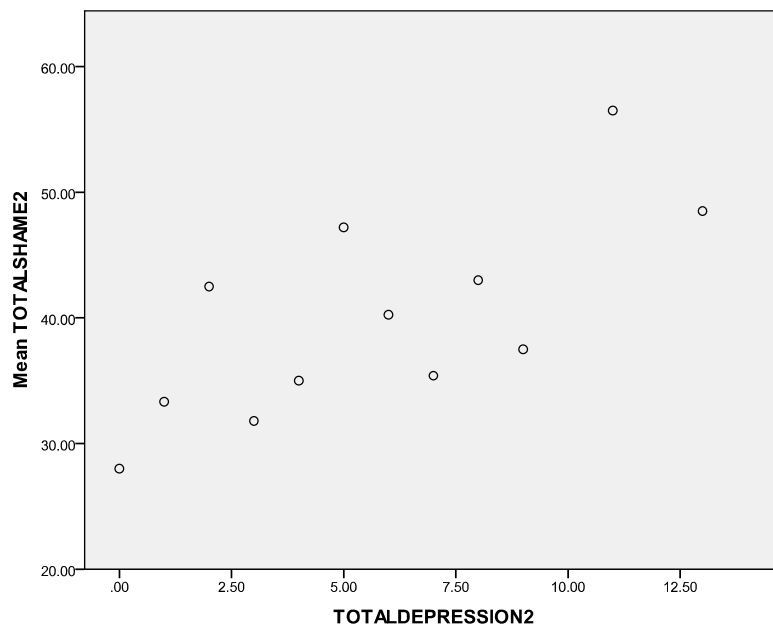
Table 3: Demographic Information of the Sample of Black Women

	N	Frequency
Age	52	24 (21yrs old-30yrs old) 12 (33yrs old-40yrs old) 10 (41yrs old-50yrs old) 3 (19yrs old-20yrs old) 3 (53yrs old-55yrs old)
Gender	52	52 (female)
BMI	47	37 (30.0 > overweight/obese) 7 (18.50-24.90; normal weight) 3 (< 18.50; underweight)
Skin Complexion	52	27 (mahogany/medium brown) 14 (fawn/light brown) 11 (dark-chocolate/dark brown)
Sexual Orientation	52	47 (heterosexual) 4 (bisexual) 1 (lesbian/gay)
Black/African American	52	45 (non-Hispanic/Latina)
Black Non-Hispanic/Latina*	45	
Marital Status	52	30 (single) 14 (married) 2 (partnered/common law) 6 (divorced)
Education Status	52	18 (college graduate) 11 (graduate student) 6 (master's degree) 4 (high school/GED) 4 (Ph.D/professional) 3 (college senior) 3 (college sophomore) 2 (college junior) 1 (college freshman)
Income	51	12 (\$30,001-\$40,000) 10 (\$80,000 >) 6 (\$40,000-\$50,000) 5 (<\$10,000) 4 (\$50,001-\$60,000) 4 (\$20,001-\$25,000) 4 (\$15,001-\$20,000) 2 (\$60,001-\$70,000) 2 (\$10,001-\$15,000) 1 (\$25,001-\$30,000) 1 (\$70,001-\$80,000)

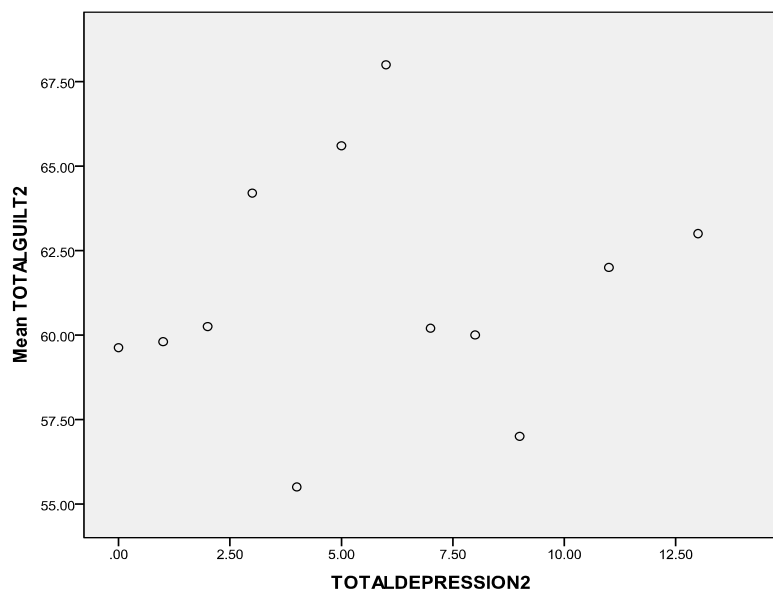
-The frequency is a representation of the actual number of participants who responded accordingly. The frequency numbers are paired with responses which are noted in parentheses. \*A total of 45 women responded and self-identified themselves as being Black non-Hispanic/Latina, and a total of 7 women did not respond to this question. These 7 women were included in the overall sample of 52 participants because they self-reported their race as being Black/African American. Therefore, all 52 respondents self-identified themselves as Black/African American.



Graph 1: Scatterplot of Shame Proneness in relations to Depression Symptoms



Graph 2: Scatterplot of Guilt Proneness and Depression Symptoms



APPENDIX B: THE DEPRESSION ANXIETY STRESS SCALE 21 (DASS-21;  
LOVIBOND AND LOVIBOND, 1995)

DASS <sub>21</sub>	Name:	Date:
<p>Please read each statement and circle a number 0, 1, 2 or 3 that indicates how much the statement applied to you <i>over the past week</i>. There are no right or wrong answers. Do not spend too much time on any statement.</p> <p><i>The rating scale is as follows:</i></p> <p>0 Did not apply to me at all</p> <p>1 Applied to me to some degree, or some of the time</p> <p>2 Applied to me to a considerable degree, or a good part of time</p> <p>3 Applied to me very much, or most of the time</p>		
1 I found it hard to wind down	0	1 2 3
2 I was aware of dryness of my mouth	0	1 2 3
3 I couldn't seem to experience any positive feeling at all	0	1 2 3
4 I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1 2 3
5 I found it difficult to work up the initiative to do things	0	1 2 3
6 I tended to over-react to situations	0	1 2 3
7 I experienced trembling (eg, in the hands)	0	1 2 3
8 I felt that I was using a lot of nervous energy	0	1 2 3
9 I was worried about situations in which I might panic and make a fool of myself	0	1 2 3
1 I felt that I had nothing to look forward to	0	1 2 3
0		
1 I found myself getting agitated	0	1 2 3
1		

1 2	I found it difficult to relax	0	1	2	3
1 3	I felt down-hearted and blue	0	1	2	3
1 4	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
1 5	I felt I was close to panic	0	1	2	3
1 6	I was unable to become enthusiastic about anything	0	1	2	3
1 7	I felt I wasn't worth much as a person	0	1	2	3
1 8	I felt that I was rather touchy	0	1	2	3
1 9	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
2 0	I felt scared without any good reason	0	1	2	3
2 1	I felt that life was meaningless	0	1	2	3

APPENDIX C: TEST OF SELF-CONSCIOUS AFFECT-3 (TOSCA-3; TANGNEY,  
DEARING, WAGNER, & GRAMZOW, 2000)

**TOSCA-3**

Below are situations that people are likely to encounter in day-to-day life, followed by several common reactions to those situations.

As you read each scenario, try to imagine yourself in that situation. Then indicate how likely you would be to react in each of the ways described. We ask you to rate all responses because people may feel or react more than one way to the same situation, or they may react different ways at different times.

For example:

A. You wake up early one Saturday morning. It is cold and rainy outside.

a) You would telephone a friend to catch up on news. 1---2---3---4---5  
not likely                      very  
likely

b) You would take the extra time to read the paper. 1---2---3---4---5  
not likely                      very  
likely

c) You would feel disappointed that it's raining. 1---2---3---4---5  
not likely                      very  
likely

d) You would wonder why you woke up so early. 1---2---3---4---5  
not likely                      very  
likely

In the above example, I've rated ALL of the answers by circling a number. I circled a "1" for answer (a) because I wouldn't want to wake up a friend very early on a Saturday morning -- so it's not at all likely that I would do that. I circled a "5" for answer (b) because I almost always read the paper if I have time in the morning (very likely). I circled a "3" for answer (c) because for me it's about half and half. Sometimes I would be disappointed about the rain and sometimes I wouldn't -- it would depend on what I had planned. And I circled a "4" for answer (d) because I would probably wonder why I had awakened so early.

Please do not skip any items -- rate all responses.

1. You make plans to meet a friend for lunch. At 5 o'clock, you realize you stood him up.

- |  |  |
|--|--|
| a) You would think: "I'm inconsiderate."                         | 1---2---3---4---5<br>not likely      very likely |
| b) You would think: "Well, they'll understand."                  | 1---2---3---4---5<br>not likely      very likely |
| c) You'd think you should make it up to him as soon as possible. | 1---2---3---4---5<br>not likely      very likely |
| d) You would think: "My boss distracted me just before lunch."   | 1---2---3---4---5<br>not likely      very likely |

2. You break something at work and then hide it.

- |  |  |
|--|--|
| a) You would think: "This is making me anxious. I need to either fix it or get someone else to." | 1---2---3---4---5<br>not likely      very likely |
| b) You would think about quitting.   | 1---2---3---4---5<br>not likely      very likely |
| c) You would think: "A lot of things aren't made very well these days."                          | 1---2---3---4---5<br>not likely      very likely |
| d) You would think: "It was only an accident."   | 1---2---3---4---5<br>not likely      very likely |

3. You are out with friends one evening, and you're feeling especially witty and attractive. Your best friend's spouse seems to particularly enjoy your company.

- |   |  |
|---|--|
| a) You would think: "I should have been aware of what my best friend is feeling." | 1---2---3---4---5<br>not likely      very likely |
| b) You would feel happy with your appearance and personality.                     | 1---2---3---4---5<br>not likely      very likely |
| c) You would feel pleased to have made such a good impression.                    | 1---2---3---4---5<br>not likely      very likely |
| d) You would think your best friend should pay attention to his/her spouse.       | 1---2---3---4---5<br>not likely      very likely |
| e) You would probably avoid eye-contact for a long time.                          | 1---2---3---4---5<br>not likely      very likely |

4. At work, you wait until the last minute to plan a project, and it turns out badly.

- |   |  |
|---|--|
| a) You would feel incompetent.  | 1---2---3---4---5<br>not likely      very likely |
| b) You would think: "There are never enough hours in the day."                | 1---2---3---4---5<br>not likely      very likely |
| c) You would feel: "I deserve to be reprimanded for mismanaging the project." | 1---2---3---4---5<br>not likely      very likely |
| d) You would think: "What's done is done."                                    | 1---2---3---4---5<br>not likely      very likely |

5. You make a mistake at work and find out a co-worker is blamed for the error.

- |   |  |
|---|--|
| a) You would think the company did not like the co-worker.    | 1---2---3---4---5<br>not likely      very likely |
| b) You would think: "Life is not fair."                       | 1---2---3---4---5<br>not likely      very likely |
| c) You would keep quiet and avoid the co-worker.              | 1---2---3---4---5<br>not likely      very likely |
| d) You would feel unhappy and eager to correct the situation. | 1---2---3---4---5<br>not likely      very likely |

6. For several days you put off making a difficult phone call. At the last minute you make the call and are able to manipulate the conversation so that all goes well.

- |  |  |
|--|--|
| a) You would think: "I guess I'm more persuasive than I thought."            | 1---2---3---4---5<br>not likely      very likely |
| b) You would regret that you put it off.                                     | 1---2---3---4---5<br>not likely      very likely |
| c) You would feel like a coward.   | 1---2---3---4---5<br>not likely      very likely |
| d) You would think: "I did a good job."                                      | 1---2---3---4---5<br>not likely      very likely |
| e) You would think you shouldn't have to make calls you feel pressured into. | 1---2---3---4---5<br>not likely      very likely |

7. While playing around, you throw a ball and it hits your friend in the face.

- |   |  |
|---|--|
| a) You would feel inadequate that you can't even throw a ball.        | 1---2---3---4---5<br>not likely      very likely |
| b) You would think maybe your friend needs more practice at catching. | 1---2---3---4---5<br>not likely      very likely |
| c) You would think: "It was just an accident."                        | 1---2---3---4---5<br>not likely      very likely |
| d) You would apologize and make sure your friend feels better.        | 1---2---3---4---5<br>not likely      very likely |

8. You have recently moved away from your family, and everyone has been very helpful. A few times you needed to borrow money, but you paid it back as soon as you could.

- |  |  |
|--|--|
| a) You would feel immature.                            | 1---2---3---4---5<br>not likely      very likely |
| b) You would think: "I sure ran into some bad luck."   | 1---2---3---4---5<br>not likely      very likely |
| c) You would return the favor as quickly as you could. | 1---2---3---4---5<br>not likely      very likely |
| d) You would think: "I am a trustworthy person."       | 1---2---3---4---5<br>not likely      very likely |
| e) You would be proud that you repaid your debts.      | 1---2---3---4---5<br>not likely      very likely |

9. You are driving down the road, and you hit a small animal.

- |   |  |
|---|--|
| a) You would think the animal shouldn't have been on the road.      | 1---2---3---4---5<br>not likely      very likely |
| b) You would think: "I'm terrible."                                 | 1---2---3---4---5<br>not likely      very likely |
| c) You would feel: "Well, it was an accident."                      | 1---2---3---4---5<br>not likely      very likely |
| d) You'd feel bad you hadn't been more alert driving down the road. | 1---2---3---4---5<br>not likely      very likely |

10. You walk out of an exam thinking you did extremely well. Then you find out you did poorly.

- |   |  |
|---|--|
| a) You would think: "Well, it's just a test."         | 1---2---3---4---5<br>not likely      very likely |
| b) You would think: "The instructor doesn't like me." | 1---2---3---4---5<br>not likely      very likely |
| c) You would think: "I should have studied harder."   | 1---2---3---4---5<br>not likely      very likely |
| d) You would feel stupid.                             | 1---2---3---4---5<br>not likely      very likely |

11. You and a group of co-workers worked very hard on a project. Your boss singles you out for a bonus because the project was such a success.

- |   |  |
|---|--|
| a) You would feel the boss is rather short-sighted.     | 1---2---3---4---5<br>not likely      very likely |
| b) You would feel alone and apart from your colleagues. | 1---2---3---4---5<br>not likely      very likely |
| c) You would feel your hard work had paid off.          | 1---2---3---4---5<br>not likely      very likely |
| d) You would feel competent and proud of yourself.      | 1---2---3---4---5<br>not likely      very likely |
| e) You would feel you should not accept it.             | 1---2---3---4---5<br>not likely      very likely |



12. While out with a group of friends, you make fun of a friend who's not there.

- |   |                             |
|---|-----------------------------|
| a) You would think: "It was all in fun; it's harmless."                                       | 1---2---3---4---5           |
|   | not likely      very likely |
| b) You would feel small...like a rat.   | 1---2---3---4---5           |
|   | not likely      very likely |
| c) You would think that perhaps that friend should have been there to defend himself/herself. | 1---2---3---4---5           |
|   | not likely      very likely |
| d) You would apologize and talk about that person's good points.                              | 1---2---3---4---5           |
|   | not likely      very likely |

13. You make a big mistake on an important project at work. People were depending on you, and your boss criticizes you.

- |  |                             |
|--|-----------------------------|
| a) You would think your boss should have been more clear about what was expected of you. | 1---2---3---4---5           |
|  | not likely      very likely |
| b) You would feel like you wanted to hide.   | 1---2---3---4---5           |
|  | not likely      very likely |
| c) You would think: "I should have recognized the problem and done a better job."        | 1---2---3---4---5           |
|  | not likely      very likely |
| d) You would think: "Well, nobody's perfect."  | 1---2---3---4---5           |
|  | not likely      very likely |

14. You volunteer to help with the local Special Olympics for handicapped children. It turns out to be frustrating and time-consuming work. You think seriously about quitting, but then you see how happy the kids are.

- |   |                             |
|---|-----------------------------|
| a) You would feel selfish and you'd think you are basically lazy.                     | 1---2---3---4---5           |
|   | not likely      very likely |
| b) You would feel you were forced into doing something you did not want to do.        | 1---2---3---4---5           |
|   | not likely      very likely |
| c) You would think: "I should be more concerned about people who are less fortunate." | 1---2---3---4---5           |
|   | not likely      very likely |
| d) You would feel great that you had helped others.                                   | 1---2---3---4---5           |
|   | not likely      very likely |
| e) You would feel very satisfied with yourself.                                       | 1---2---3---4---5           |
|   | not likely      very likely |

15. You are taking care of your friend's dog while they are on vacation and the dog runs away.

- |  |  |
|--|--|
| a) You would think, "I am irresponsible and incompetent."  | 1---2---3---4---5<br>not likely      very likely |
| b) You would think your friend must not take very good care of their dog or it wouldn't have run away. | 1---2---3---4---5<br>not likely      very likely |
| c) You would vow to be more careful next time.   | 1---2---3---4---5<br>not likely      very likely |
| d) You would think your friend could just get a new dog.   | 1---2---3---4---5<br>not likely      very likely |

16. You attend your co-worker's housewarming party and you spill red wine on their new cream-colored carpet, but you think no one notices.

- |   |  |
|---|--|
| a) You think your co-worker should have expected some accidents at such a big party.      | 1---2---3---4---5<br>not likely      very likely |
| b) You would stay late to help clean up the stain after the party.                        | 1---2---3---4---5<br>not likely      very likely |
| c) You would wish you were anywhere but at the party.                                     | 1---2---3---4---5<br>not likely      very likely |
| d) You would wonder why your co-worker chose to serve red wine with the new light carpet. | 1---2---3---4---5<br>not likely      very likely |

## APPENDIX D: DEMOGRAPHIC SHEET

### Demographic Sheet

Directions: Please answer each question by filling in the blank, checking the blank, or clicking on the circle or box that best describes you.

1. What is your current age? \_\_\_\_\_
2. What is your gender? \_\_\_\_\_Male \_\_\_\_\_Female \_\_\_\_\_Other
3. Sexual Orientation:
  - a. Heterosexual\_\_\_\_\_
  - b. Lesbian/Gay\_\_\_\_\_
  - c. Bisexual\_\_\_\_\_
4. Please provide the following information:
  - a. Weight\_\_\_\_\_
  - b. Height\_\_\_\_\_
5. What is your racial or ethnic background? Select which one you closely identify with the most:  
\_\_\_\_\_ Hispanic or Latino/a \_\_\_\_\_ American Indian/Alaskan Native  
\_\_\_\_\_ Asian or Asian American \_\_\_\_\_ Native Hawaiian or other Pacific Islander  
\_\_\_\_\_ Black or African American \_\_\_\_\_ White  
Other (Please specify) \_\_\_\_\_
6. If you identified as Black/African American please denote the following:
  - a. \_\_\_\_\_Black non-Hispanic/Latina
  - b. \_\_\_\_\_Black Hispanic/Latina

c. In addition, please describe your self-perception of your skin tone. Select which one you closely identify with the most:

- i. ☐ fawn/light brown skin complexion
- ii. ☐ mahogany/medium brown skin complexion
- iii. ☐ dark-chocolate/dark brown skin complexion

7. What is your current relationship status? ☐ Single ☐ Married  
☐ Partnered/Common Law ☐ Divorced ☐ Separated  
☐ Widowed

8. What is your highest educational attainment?

- ☐ Less than high school graduate
- ☐ High school graduate or GED
- ☐ Current College freshman
- ☐ Current College sophomore
- ☐ Current College junior
- ☐ Current College senior
- ☐ College graduate
- ☐ Currently pursuing a graduate degree
- ☐ Master's degree
- ☐ PhD or professional degree (MD, JD, etc)

9. What is your annual family income level?

- ☐ Less than \$10,000
- ☐ \$10,001 to \$15,000
- ☐ \$15,001 to \$20,000
- ☐ \$20,001 to \$25,000
- ☐ \$25,001 to \$30,000
- ☐ \$30,001 to \$40,000
- ☐ \$40,001 to \$50,000
- ☐ \$50,001 to \$60,000
- ☐ \$60,001 to \$70,000
- ☐ \$70,001 to \$80,000
- ☐ \$80,001 or more

## APPENDIX E: PARTICIPANT INFORMATION & INFORMED CONSENT

### PARTICIPANT INFORMATION

The Relationship of Guilt Proneness or Shame Proneness to Binge Eating among Women

Hi, my name is Amber McCadney. I am a master's student in Community Counseling at Oklahoma State University. I am inviting women to participate in my thesis project and ask that you take a few minutes to read this invitation which explains my project to determine if this is something you would be interested in participating in voluntarily.

The primary investigator for this project is Amber McCadney B.A., M.S. Community Counseling student; her advisor is Dr. Julie Dorton-Clark, Ph.D.

The purpose of my study is to examine binge eating (BE) behaviors in relationship to guilt, shame, depression, body image and body mass index among women.

At the bottom of this page you will be able indicate whether or not you would like to participate in this research study ("accept"), or not ("decline"). If you accept, you will be directed to online questionnaires on a Frontpage website. There will be five questionnaires asking questions about depression, guilt, shame, eating behaviors, body image and a demographic form. It is estimated that completion of the questionnaires will take approximately 40 to 60 minutes. At any time throughout the survey, you can opt to discontinue. There is no compensation for participating.

No personally identifying information such as your name or contact information will be collected. All your responses will be anonymous and securely password protected. Only the primary investigator and her advisor will have access to the secure data. Also, there are no known risks associated with this project which are greater than those ordinarily encountered in daily life.

There are no direct benefits to you other than what you learn from answering the questions and knowing that you are helping research. However, there may be future benefits to other women as we learn more about the relationships, influences and emotions that accompany binge eating among women from all walks of life. Identifying

these relationships may help counselors and mental health care workers to be more aware of how such relationships can contribute to disorder eating behaviors in women.

Please contact the investigator or her advisor if any questions or concerns about this research study arise. Their contact information is below.

Primary investigator:

Amber McCadney, BA, M.S. Community Counseling Student  
Oklahoma State University  
[mccadne@okstate.edu](mailto:mccadne@okstate.edu)  
405-744-2899

Advisor:

Dr. Julie Dorton-Clark, Ph.D.  
Oklahoma State University  
[Julz.dorton@okstate.edu](mailto:Julz.dorton@okstate.edu)  
405-744-2899

If you have questions about your rights as a research volunteer, you may contact Dr. Shelia Kennison, IRB Chair, 219 Cordell North, Stillwater, OK 74078, 405-744-3377 or [irb@okstate.edu](mailto:irb@okstate.edu).

Consent: I have read and fully understand this consent form. I understand that my participation is voluntary. By clicking below, I am indicating that I freely and voluntarily and agree to participate in this study and I also acknowledge that I am at least 18 years of age.

It is recommended that you print a copy of this consent page for your records before you begin the study by clicking below.

ACCEPT

DECLINE

## APPENDIX F: INSTITUTIONAL REVIEW BOARD APPROVAL

### Oklahoma State University Institutional Review Board

Date: Tuesday, April 27, 2010  
IRB Application No ED1057  
Proposal Title: The Relationship of Guilt Proneness or Shame Proneness to Binge Eating Among Women  
Reviewed and Processed as: Expedited

Status Recommended by Reviewer(s): Approved Protocol Expires: 4/26/2011

Principal Investigator(s):

Amber McCadney	Julie Dorton Clark
140 N. Duck Apt. 49	421 Willard
Stillwater, OK 74075	Stillwater, OK 74078

The IRB application referenced above has been approved. It is the judgment of the reviewers that the rights and welfare of individuals who may be asked to participate in this study will be respected, and that the research will be conducted in a manner consistent with the IRB requirements as outlined in section 45 CFR 46.

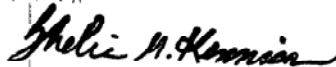
☒ The final versions of any printed recruitment, consent and assent documents bearing the IRB approval stamp are attached to this letter. These are the versions that must be used during the study.

As Principal Investigator, it is your responsibility to do the following:

1. Conduct this study exactly as it has been approved. Any modifications to the research protocol must be submitted with the appropriate signatures for IRB approval.
2. Submit a request for continuation if the study extends beyond the approval period of one calendar year. This continuation must receive IRB review and approval before the research can continue.
3. Report any adverse events to the IRB Chair promptly. Adverse events are those which are unanticipated and impact the subjects during the course of this research; and
4. Notify the IRB office in writing when your research project is complete.

Please note that approved protocols are subject to monitoring by the IRB and that the IRB office has the authority to inspect research records associated with this protocol at any time. If you have questions about the IRB procedures or need any assistance from the Board, please contact Beth McTernan in 219 Cordell North (phone: 405-744-5700, beth.mcternan@okstate.edu).

Sincerely,



Shelia Kennison, Chair  
Institutional Review Board

# VITA

Amber McCadney

Candidate for the Degree of

Master of Science

Thesis: THE RELATIONSHIP OF GUILT PRONENESS AND SHAME PRONENESS  
AMONG AFRICAN AMERICAN WOMEN

Major Field: Counseling

Biographical:

Personal Data: B.A. in Psychology, University of Missouri-Columbia,  
Columbia, Missouri, May 2006.

Education: Completed the requirements for the Master of Science in  
Counseling, Community Track at Oklahoma State University, Stillwater,  
OK, U.S.A. in July 2010.

Experience:

Washington University School of Medicine, Professional Rater I from July  
2006 to January 2008.

Payne County Youth Services, Practicum Intern from June 2009 to May  
2010.

Professional Memberships: Chi Sigma Iota Honor Society

Psi Chi Honor Society

American Counseling Association

Association for Behavioral and Cognitive Therapies



Name: Amber McCadney

Date of Degree: July, 2010

Institution: Oklahoma State University

Location: Stillwater, Oklahoma

Title of Study: THE RELATIONSHIP OF GUILT PRONENESS AND SHAME  
PRONENESS AMONG AFRICAN AMERICAN WOMEN

Pages in Study: 68

Candidate for the Degree of Master of Science

Major Field: Community Counseling

Scope and Method of Study:

Research conducted on depressive symptoms among the Black American female populations has been limited as far as addressing the associated emotions and behaviors related to depressive symptoms from a culturally relevant scope. This study looked at depressive symptoms among a sample of Black American females in relationship to self-reports of shame proneness and guilt proneness. It was hypothesized that self-reports of shame proneness would be related to self-reports of depressive symptoms and that self-reports of guilt proneness would be related to self-reports of depressive symptoms.

Findings and Conclusions:

This study found that shame-proneness was positively and significantly related to reports of depressive symptoms. Guilt proneness and depressive symptoms were not significantly related to each other but did display a positive directional association. After extensive literature reviews, the current study is one of the only empirical investigations that has examined an association of shame proneness and guilt proneness to depressive symptoms in a sample of Black women.

ADVISER'S APPROVAL: Dr. Julie Dorton-Clark

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ADVISER'S APPROVAL: Dr. Julie Dorton-Clark

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