

The Social Sharing of emotions in HIV/AIDS: A comparative study of HIV/AIDS, Diabetes and Cancer Patients

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Abstract:	<p>Studies have shown that chronic illness patients encounter difficulties in the Social Sharing of Emotions (SSE). Do HIV/AIDS patients present distinguishing traits in the inhibition of illness and non-illness related emotions? The differences in the SSE between 35 HIV/AIDS, 35 diabetes and 34 cancer outpatients were studied. A questionnaire assessed illness-related emotions, SSE and emotional inhibition. The HIV/AIDS group significantly presented: superior scoring in shame, guilt and non-sharing of illness-related emotions, lower frequencies of SSE and less sharing partners. These findings could lead to future research examining the emotional expression of guilt and shame in HIV/AIDS.</p>

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The Social Sharing of emotions in HIV/AIDS: A comparative study of HIV/AIDS, Diabetes and Cancer Patients

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Authors' notes

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SOCIAL SHARING OF EMOTIONS IN HIV/AIDS

The Social Sharing of Emotions in HIV/AIDS: A comparative study of HIV/AIDS, Diabetes and Cancer Patients**Introduction**

Previous research on the social aspects of emotional regulation has shown that individuals communicate their emotions. The propensity to speak and share emotional experiences has been thoroughly investigated and denoted as the Social Sharing of Emotions (SSE) (Rimé et al., 1991; Rimé et al., 1992; Rimé, 2009). SSE has been defined as “the evocation of an emotion by the means of socially shared language, at the presence, at least symbolic, of an addressee to whom the emotion is evoked” (Rimé, 2007, p. 86). Evidence shows that 80% to 95% of emotional experiences, negative or positive, are object of SSE. This propensity to speak about emotional experiences is manifested during the hours, days, weeks or sometimes months following the emotional episode.

SSE studies have thoroughly supported that, following mayor life negative events, (e.g. Sydor & Philippot, 1996) as well as daily life events (e.g., Rimé et al., 1991), people look for the company of others to share and talk about the emotion-eliciting event (Rimé, 2009). Accordingly, SSE can result in positive outcomes both at inter- and intra- personal levels. As addressed by Rime et al. (1998), some of the benefits and functions served by the SSE are: (1) constructing and consolidating memory of important events, (2) processing and completing the emotional memory, (3) enhancing interpersonal relationships and social integration, and (4) constructing and disseminating social knowledge on emotion. On the one hand, at the interpersonal level, social sharing may bring forth emotional contagion, empathy, attachment and strengthened social ties between sharing persons and their listeners (Rimé, 2009;

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2
3 Christophe & Rimé, 1997). On the other hand, at the intrapersonal level, SSE may result
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5 in cognitive benefits such as making meaning of the situation when the sharing mode
6
7 takes place in a cognitive reappraisal fashion (Nils & Rimé, 2012).
8

9
10 As raised by Lepore et al. (2000), talking about stressful experiences allows
11
12 individuals to construct an organized narrative which becomes part of individuals'
13
14 cognitive representation of the stressor. Therefore, succeeding the emotional impact
15
16 linked to a physical illness, it is plausible to consider that SSE can provide a positive
17
18 contribution to emotional adjustment as well as to social integration. For instance,
19
20 previous research has shown that prostate cancer survivors who benefit from high
21
22 quality social interactions cope better with cancer-related thoughts and present an
23
24 enhanced mental health (Lepore & Helgeson, 1998).
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27
28 Research has shown that patients in general are quite eager to share their illness-
29
30 related emotions. To illustrate, Cardiac patients anticipating surgery shared their
31
32 emotional distress in 91% of cases (Panagopoulou et al., 2006). However, previous
33
34 research has also shown that chronic illness patients encounter emotional inhibition and
35
36 difficulties in the social sharing of illness-related emotions. Herbette & Rimé (2004)
37
38 observed that chronic pain patients frequently inhibited their emotions to protect
39
40 themselves from rejection by their significant others. These findings confirmed previous
41
42 research showing that people who suffer from life threatening conditions may face a
43
44 self-threatening dilemma (Silver, Wortman & Crofton, 1990): They feel the need to
45
46 communicate their distress in order to incite others to provide social support, but at the
47
48 same time, they run the risk of receiving negative responses from others when they
49
50 express their suffering.
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54 Social constraints (individuals' perception that others are unreceptive to hearing
55
56 about their negative experience) linked to emotional disclosure in chronic diseases have
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2
3 been thoroughly examined: for example, social constraints linked to cancer (Lepore &
4
5 Revenson, 2007) and linked to diabetes management (Braitman, et al., 2008). Likewise,
6
7 previous research has been attentive to emotional distress in chronic conditions. For
8
9 instance, studies have focused on emotional distress among diabetes patients (Snoeck et
10
11 al., 2000; DeCoster, 2003). Moreover, difficulties in the verbalization of emotions have
12
13 been found among some diabetes patients (Luminet et al., 2006).

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15
16 Progress in anti-retro-viral (ARV) medication has led to the consideration of
17
18 HIV/AIDS as a chronic illness (Kelly et al., 1998). However, stigma, social rejection
19
20 and isolation still characterize HIV/AIDS infection. Previous studies have evidenced the
21
22 difficult challenge faced by these patients when coping with negative emotions linked to
23
24 the HIV/AIDS experience (Siegel & Schrimshaw, 2000). Moreover, individuals living
25
26 with an HIV/AIDS condition experience the loss of social support and are rejected by
27
28 their social network (Muma et al., 1995), which can result in isolation. Such social and
29
30 emotional burdens can result in negative outcomes. To illustrate, Gore-Felton et al.
31
32 (2002) have evidenced an association of social support and of emotion focused coping
33
34 strategies with risky sexual behaviours in HIV-positive men and women. HIV/AIDS is
35
36 thus a chronic illness suitable to an investigation from the perspective of SSE and social
37
38 constraints.
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43 Prior research conducted with HIV/AIDS populations (Bigner & Bozzet, 1989;
44
45 Doll et al., 1994; Moneyham et al., 1996; Derlega et al., 2002) has shown that these
46
47 patients fear others' negative responses. For example, Derlega et al. (2002) observed an
48
49 association between a heightened perception of HIV-related stigma and the anticipation
50
51 of potential negative consequences of disclosing the HIV diagnosis to a friend or a
52
53 parent (ex., fear of rejection). Even though individuals facing different chronic
54
55 conditions or diseases can experience stigmatisation (Van Brakel, 2006; Jones et al.,
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2
3 1984), stigmatising responses vary from one condition to another. Few modern illnesses
4
5 have been as widely stigmatised as HIV/AIDS: despite the extensive mass-media and
6
7 health campaigns, a fear of being infected with HIV through mere social interactions as
8
9 well as the association of HIV to death, still remain (Black & Miles, 2002). Therefore,
10
11 in the particular case of HIV/AIDS, contagiousness (Dijker, Koomen & Kok, 1997;
12
13 Dijker & Raeijmaekers, 1999) of the disease and personal responsibility (Weiner, Perry
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15 & Magnusson, 1998) associated to the sexual transmission of the disease, are specific
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17 factors that determine others' reactions to infected people. Therefore, perceived
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19 contagiousness, perceived seriousness, personal responsibility and norm-violating
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21 behaviours often associated with HIV infection colour HIV/AIDS related stigma (Bos et
22
23 al., 2008).

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27 For instance, an important dimension of stigmas is the degree to which they can
28
29 be concealed from others (Jones et al., 1984). In the case of HIV, even though the
30
31 visibility of the stigma relies upon disease progression and symptoms, concealing
32
33 serostatus can be an option for these patients (e.g. Black & Miles, 2002). A previous
34
35 study (Frabble et al., 1998) suggested that when compared to individuals facing a
36
37 visible stigma (ex. overweight), those facing a concealable stigma (ex. sexual
38
39 orientation) were found to show more anxiety, depression, and negative affect, and less
40
41 self-esteem.

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44
45 Along another line, Fife and Wright (2000) compared the dimensionality of
46
47 stigma and its impact on the self in Cancer patients and in HIV/AIDS patients. They
48
49 found HIV infected persons to report higher feelings of social rejection, internalised
50
51 shame and social isolation. In a similar vein, Fernandes et al. (2007), compared
52
53 laypersons' stigma perception towards patients having Epilepsy, AIDS or Diabetes, and
54
55 found AIDS to be the most stigmatised disease and Diabetes the least one.

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3 To our knowledge, studies have not yet compared different chronic conditions
4 with respect to emotional inhibition linked to the perception of social responses (e.g.,
5 social constraints, self-disclosure, secrecy). The investigation reported in this article
6 finds its roots in previous findings concerning difficulties with SSE amongst chronic
7 illness patients (Herbette & Rimé, 2004) and **emotional inhibition** of illness resulting
8 from the perception of others' negative responses (e.g., Lepore & Revenson, 2007). Yet,
9 we hypothesized that the social aspects (ex. stigma, reject, isolation and ostracism)
10 specific to this sexually transmitted infectious disease would differentiate HIV/AIDS
11 patients with regard to SSE variables when compared to other (non-contagious) chronic
12 illness patients such as diabetics and cancer patients.
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25 Do HIV/AIDS patients manifest distinguishing traits in the inhibition of illness
26 and non-illness related emotions? This study's main objective was to examine the
27 differences in SSE between HIV/AIDS, diabetes and cancer patients. Previous findings
28 have evidenced low illness disclosure levels among HIV/AIDS patients as well as
29 HIV/AIDS patients' fears concerning others' negative responses (e.g., Derlega et al.,
30 2002). We thus hypothesised that when compared to diabetes and cancer patients,
31 HIV/AIDS patients would share less their illness related emotions. Furthermore, it was
32 hypothesized that the HIV/AIDS group would differ from the comparison groups for
33 negative emotions: for instance, HIV/AIDS patients would experience greater shame
34 (Fife & Wright, 2000).
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47 **As a result of the predicted heightened inhibition of illness-related emotions in**
48 **HIV/AIDS patients, we expect two potential consequences. On the one hand, we**
49 **hypothesize that when compared to diabetes and cancer patients, HIV/AIDS patients**
50 **experience an excess of cognitive manifestations such as intrusive thoughts, mental**
51 **rumination, and search for meaning.** Evidence has shown that secrecy involves active
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3 inhibition and suppression of thoughts and feelings (e.g., Pennebaker, 1989; Kelly,
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5 2002). For instance, Finkenauer and Rimé (1998) found that when compared to shared
6
7 emotional events, non-shared emotional events resulted in greater search for meaning
8
9 efforts to understand what happened, as well as in greater feelings of shame. On the
10
11 other hand, the numerous social threats linked to HIV/AIDS, together with their
12
13 inhibited sharing of the illness experience, leads us to expect that these patients should
14
15 report reduced social support and a lower social integration.
16
17

Method*Participants*

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22 The following study was conducted in the Dominican Republic: 35 HIV/AIDS
23
24 outpatients, 35 diabetes outpatients and 34 cancer outpatients were matched in age,
25
26 gender and educational level. Table 1 displays the various characteristics of participants
27
28 by group: age, sex, educational level, time of diagnosis and marital status. Marital status
29
30 was not considered in the matching criteria, yet, no significant differences were found
31
32 between the three groups ($\chi^2(104, 2) = 3.13$; NS). As to time of diagnosis, when
33
34 measured in months, significant differences were found ($F(2,101) = 11.85$; $p < 0.01$; $\eta^2 =$
35
36 0.19). Post Hoc Tests ($p < 0.01$) manifested that the cancer group ($M = 20.62$; $SD =$
37
38 26.88) significantly differed from both the HIV/AIDS group ($M = 66.40$; $SD = 64.89$)
39
40 and the diabetes group ($M = 84.44$; $SD = 84.43$).
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45 All HIV/AIDS patients were under ARV medication, a precondition for
46
47 enrollment in this study. The mean CD4 count in the sample was 233.20 (cells/mm³)
48
49 measured on average 5.27 months before the study. Within the HIV/AIDS group,
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51 97.14% (N = 34) of patients reported having been infected with HIV through
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53 heterosexual sexual intercourse, and the remaining 2.85% (N = 1) reported having been
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55 infected with HIV through homosexual sexual intercourse.
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3 As to diabetes patients, 62.86% of them were undergoing treatment with insulin
4 injections and the remaining 37.14% were not insulin dependent. Information on the
5 type of diabetes diagnosis was not assessed. Within the cancer group, 44.12% were
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7
8 undergoing chemotherapy, 11.76% radiotherapy, 38.23% both chemotherapy and
9
10 radiotherapy, and the remaining 5.88% were not undergoing any treatment. Within this
11
12 group, all women (N = 20; 58.82% of the cancer sample) had a breast cancer diagnosis.
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14 As to the remaining 41.18% of the sample (male participants), 5.88% were diagnosed
15
16 with lymphoma, 14.70% had a colon cancer diagnosis, 5.88% were diagnosed with
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18 prostate cancer, and 14.70% were diagnosed with other types of cancer.
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22 The existence of a certain level of heterogeneity in this sample can be argued.
23
24 For instance, the types of cancer diagnosis and treatments as well as in the type of
25
26 diabetes diagnoses vary within these illness groups. However, it is important to
27
28 recognize the difficulties that can be encountered when conducting this type of research.
29
30 For example, it can be difficult to respect matching criteria (e.g. HIV/AIDS populations
31
32 can be quite young when compared to Cancer populations).
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35

36 Insert Table 1 about here.

37 38 *Procedure*

39
40 Patients were sampled in six different health care institutions: HIV/AIDS patients in two
41
42 different HIV units belonging to the National HIV/AIDS Control Program of the
43
44 Dominican Republic's Ministry of Health, Diabetes patients in a non-lucrative diabetes
45
46 clinic, and cancer patients in two private non-lucrative oncology clinics and in one
47
48 private oncology clinic. Previous authorization was obtained from the pertaining direction
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50 board for each institution.
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54 A doctor, nurse or other medical staff informed patients about the study and
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56 proposed volunteer participation. Patients were informed that it consisted of research
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concerning emotional expression in chronic diseases, as part of an international university research program. The length of the interviews (approximately 40 minutes) and their confidentiality were announced. If patients volunteered, the researcher met with the patient. Respondents did not receive any kind of compensation for their participation. Informed consent was obtained from all participants.

Questionnaires were administered in an interview modality to ensure comprehension, only the researcher and the patient were present at the time of the interview. One single researcher interviewed all patients at the different health care institutions. Interviews took place in doctors' examination rooms or at the waiting rooms before or after patients' medical appointments.

Measures

A questionnaire (in Spanish) was administered. Most measures consisted of items to be rated upon likert scales. Some items were developed in Spanish for this study, others consisted of existing SSE measures that were translated from French into Spanish, and an existing Spanish validation was used for the social support measure. One of the researchers, fluent in Spanish and French translated the items. The final version of the entire questionnaire was reviewed by three Dominican lay-individuals to ensure the conceptual meaning of each question.

General Information was obtained through questions concerning age, sex, level of education (last level reached) and marital status.

Illness history, perception, emotional and cognitive impact were obtained. Some open questions assessed information about patients' illness history: time of diagnosis, time of treatment, and type of treatment. For the HIV/AIDS group, the last CD4 count was obtained from medical records under patients' consent.

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3 **Patients'** perception of others' negative evaluation of the illness was assessed.
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5 Four items, to be rated upon likert scales (1=not at all; 5=extremely), were developed to
6
7 evaluate patients' perceptions of others' responses when disclosing about their illness: (1)
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9 fear of rejection (*I rather not talk about my illness and my illness related emotions so that*
10
11 *others do not reject me*); (2) lack of understanding of the illness and illness-related
12
13 experiences (*I have the feeling that people around me are not capable of understanding my*
14
15 *illness and what I am going through*); (3) fear of indiscretion (*I fear that if I speak about*
16
17 *my illness and my illness related emotions with those around me, they will be indiscreet*
18
19 *about my personal and intimate information*); (4) fear to reflect a negative image of the
20
21 self (*If I speak about my illness and my illness-related emotions, others will perceive a*
22
23 *negative image of me*).

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27 Furthermore, two questions ($\alpha = 0.72$) were developed to assess patients' own
28
29 perception of illness severity: (1) *How sick do you feel*, (2) *Does your illness disturb your*
30
31 *daily life?* (1=not at all; 5=extremely). Illness-related negative emotions were assessed
32
33 through 6 items developed for the current study. **Participants were asked to answer on a**
34
35 **5-point scale (1 = not at all; 5 = very much) to what extent their illness caused in them:**
36
37 ***anxiety, worry, fear, anger, guilt and shame*** (e.g. *When I think about my illness I feel*
38
39 ***shame***).

40
41
42 As to illness-related cognitive manifestation, scores for mental rumination,
43
44 intrusive thoughts and search of meaning were obtained by averaging scores for each of
45
46 these three aspects of cognitive manifestations of the illness. A total of 10 items were
47
48 **translated into Spanish, and were scattered as follows:** (1) three items (Zech & Rimé,
49
50 2005) assessed mental rumination ($\alpha = 0.82$; ***Ex: During the past week, have you had***
51
52 ***through your mind thoughts, images, memories about your illness?***; 1 = not at all; 5 =
53
54 very much), (2) two items (Zech & Rimé, 2005) assessed intrusive thoughts ($\alpha = 0.71$; ***Ex:***
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3 *During the past week I have tried not to think about my illness*; 1 = not at all; 5 = very
4
5 much), and (3) five items (Finkenauer & Rimé, 1998) assessed the search for meaning
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7 ($\alpha=0.86$; Ex: *Today, when I think about my illness I feel the need to understand why and*
8
9 *how?*).

10
11 *Disclosure of diagnosis and Social sharing of illness related emotions* were
12
13 assessed. To estimate diagnosis disclosure, an open response item was developed asking
14
15 participants to mention the number of people to whom they had disclosed their diagnosis.
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17

18
19 Participants' beliefs about benefits resulting from SSE were assessed through
20
21 five items ($\alpha = 0.83$; Herbette & Rimé, 2004) translated from French to Spanish.
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23 Patients were asked to rate on a 6-point likert scale (1= not at all; 6 = very much) to
24
25 what extent they believed SSE to be beneficial: (1) to others, (2) to themselves, (3) to
26
27 the person who shares the emotions, (4) to the person who listens to others' emotions,
28
29 (5) to themselves when sharing illness-related emotions.
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31
32 In addition, five items (Rimé et al., 1991) assessed aspects of SSE specific to
33
34 illness-related emotions: (1) desire to share illness-related emotions (*During the past week,*
35
36 *to what extent, have you felt the desire to share your illness-related emotions and*
37
38 *feelings?*; 1=not at all; 5=very much); (2) frequency of SSE during the previous week
39
40 (*During the past week, how frequently have you shared your illness-related emotions and*
41
42 *feelings?*; 1=not at all; 5=very much); (3) number of sharing partners during the previous
43
44 week (*During the past week, with how many different people have you shared your illness-*
45
46 *related emotions and feelings?*); (4) number of sharing partners during the previous month
47
48 (*During the past month, with how many different people have you shared your illness-*
49
50 *related emotions and feelings?*). One item assessed the SSE of non-illness related emotions
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52 (*Usually, in your daily life, do you share with others your emotions and feelings not*
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54 *related to your illness?*; 1=not at all; 5=very much). These items were translated from the
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original French version (Rime et al., 1991) and the wording was adapted to the illness context.

Lastly, three items ($\alpha = 0.88$), were developed to assess the non-sharing of illness-related emotions and emotional aspects kept secret. Participants rated their answers for the following questions on 5-point scales (1=Not at all; 5=extremely): (1) *Are there thoughts, feelings or emotions linked to your illness that you have never shared with anyone?* (2) *Are there thoughts, feelings or emotions linked to your illness that you do not want to share with anyone?* (3) *Do you deliberately avoid talking about your illness?*

Social Integration was assessed through the three items of the Spanish short version (Basabe, 2003) of the Social Support Appraisals Scale (Vaux et al, 1986). Two other items assessed participants' satisfaction with their social support (*In general, do you feel satisfied with the practical support that you receive from others? In general, do you feel satisfied with the emotional support that you receive from others?*). These items were to be rated upon 5 point likert scales (1=Not at all; 5=extremely; $\alpha = 0.81$).

Due to the important number of variables considered, as well as to the heterogeneity of measures of stigma linked to health (e.g. different measures for different diseases), it was decided to develop, in Spanish, a few items to evaluate patients' perceptions of others' stigmatising responses. Recently, Earnshaw and Quinn (2011) have addressed this issue. Therefore, four items ($\alpha = 0.84$), to be rated upon likert scales (1=Not at all; 5=extremely), were developed to assess participants' perception of social exclusion linked to the illness (e.g., *To what extent do you feel rejected by others due to your illness?*; *To what extent do you feel alone due to your illness?*).

Results

Illness perception, emotional and cognitive impact

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3 Patients' perception of others' negative responses when disclosing about their
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5 illness yielded a number of significant effects. MANOVA was carried out to evaluate
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7 group differences for the following set of variables: (1) fear of rejection, (2) lack of
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12 understanding of the illness and illness-related experiences, (3) fear of others'
13
14 indiscretion and (4) fear to reflect a negative image of the self. Results showed
15
16 significant differences between the three groups for these four variables ($F(8, 196) =$
17
18 $13.73; p < 0.01; \eta_p^2 = 0.36$). Separate ANOVAs were then conducted in order to specify
19
20 significant effects. Fear of rejection ($F(2, 101) = 49.37; p < 0.01; \eta_p^2 = 0.49$) was rated
21
22 by the HIV/AIDS group ($M = 4.29; SD = 1.53$) at a higher level than both comparison
23
24 groups (diabetes: $M = 1.97; SD = 1.60$; cancer: $M = 1.17; SD = 0.76$; Post Hoc: $p <$
25
26 0.01). The groups also differed significantly as to their perception of others' lack of
27
28 understanding of their illness and their illness-related experiences ($F(2, 101) = 12.89; p$
29
30 $< 0.01; \eta_p^2 = 0.20$). Post Hoc tests ($p < 0.01$) showed that the HIV/AIDS group ($M =$
31
32 $3.77; SD = 1.81$) and the diabetes group ($M = 3.00; SD = 1.85$) significantly differed
33
34 from the cancer group ($M = 1.76; SD = 1.21$) concerning the perception of others' lack
35
36 of understanding. As to fear of others' indiscretion ($F(2, 101) = 38.94; p < 0.01; \eta_p^2 =$
37
38 0.44), the HIV/AIDS group ($M = 4.43; SD = 1.36$) reported a significantly higher fear
39
40 than the diabetes ($M = 2.06; SD = 1.57$) and cancer ($M = 1.74; SD = 1.21$) groups (Post
41
42 Hoc: $p < 0.01$). Finally, the HIV/AIDS group ($M = 3.86; SD = 1.59$) manifested
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44 significantly higher scores for fear to reflect a negative image of themselves when
45
46 talking about the illness ($F(2, 101) = 30.47; p < 0.01; \eta_p^2 = 0.38$; Post Hoc tests:
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48 $p < 0.01$) when compared to both the diabetes ($M = 2.00; SD = 1.51$) and the cancer ($M =$
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50 $1.32; SD = 1.01$) groups.
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56 The three groups differed as to patients' perception of illness severity ($F(2, 101)$
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58 $= 8.88; p < 0.01; \eta_p^2 = 0.15$). Post Hoc tests showed that the diabetes group ($M = 2.97;$
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SD = 1.46) had higher scores than the cancer group (M = 2.19; SD = 1.24; $p < 0.05$) and the HIV/AIDS group (M = 1.69; SD = 1.13; $p < 0.01$).

Regarding negative illness-related emotions, MANOVA evidenced significant differences between the three groups for this vector of dependent variables ($F(12, 19) = 3.88$; $p < 0.01$; $\eta_p^2 = 0.20$). Separate ANOVAs accompanied with Scheffe post hoc comparisons revealed the following effects. For *fear*, the cancer group (M = 1.79; SD = 1.37) showed significantly lower scores ($F(2, 101) = 4.25$, $p < 0.05$; $\eta_p^2 = 0.08$; Post Hoc Tests: $p < 0.05$) than the HIV/AIDS group (M = 2.74; SD = 1.69) and the diabetes group (M = 2.77; SD = 1.68). As to *anger*, the diabetes group (M = 2.23; SD = 1.54) was found significantly higher ($F(2, 101) = 4.34$, $p < 0.05$; $\eta_p^2 = 0.08$; Post Hoc: $p < 0.05$) than the cancer group (M = 1.30; SD = 0.88). For *guilt*, the HIV/AIDS group (M = 2.86; SD = 1.90) showed significantly higher scores ($F(2, 101) = 6.08$, $p < 0.05$; $\eta_p^2 = 0.11$) than the cancer group (M = 1.53; SD = 1.05; Post Hoc: $p < 0.01$). As for *shame* ($F(2, 101) = 12.94$, $p < 0.01$, $\eta_p^2 = 0.20$; Post Hoc Tests: $p < 0.01$), the HIV/AIDS group (M = 3.00; SD = 1.89) significantly showed higher scores, differing from both the diabetes (M = 1.86; SD = 1.46) and cancer (M = 1.24; SD = 0.82) groups. No significant differences were found between the three groups concerning *anxiety* ($F(2, 101) = 2.95$; NS).

MANOVA, conducted for the three aspects of illness-related cognitive manifestations, yielded no significant group differences ($F(6, 198) = 1.65$; NS).

Disclosure of diagnosis and social sharing of illness related emotions

Significant differences were found among the three groups for patients' disclosure of their diagnosis. The HIV/AIDS group reported a smaller number of people to whom they had disclosed their diagnosis ($\chi^2(104, 2) = 41.23$; $p < 0.01$). Thus, 93.94% of diabetes patients and 96.88% of cancer patients reported having disclosed their

SOCIAL SHARING OF EMOTIONS IN HIV/AIDS

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2
3 diagnosis to *more than ten people*; whereas only 32.14% of HIV/AIDS patients reported
4
5 having done so.

6
7 Concerning the beliefs about beneficial consequences of SSE, the HIV/AIDS
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9 group ($M = 2.61$; $SD = 1.30$) evidenced significantly lower scores ($F(2, 101) = 13.81$;
10
11 $p < 0.01$; $\eta_p^2 = 0.21$) when compared to the diabetes ($M = 4.13$; $SD = 1.42$) and the cancer
12
13 ($M = 4.11$; $SD = 1.43$) groups (Post Hoc Tests: $p < 0.01$).

16
17 Insert Table 2 about here.

18
19 Table 2 displays the various results pertaining to the social sharing of illness-
20
21 related emotions for the three groups. MANCOVA (co-variants: guilt, shame, diagnosis
22
23 disclosure and time of diagnosis) was carried out on three of the relevant items
24
25 expected to vary in the same direction: (1) frequency of emotion sharing, (2) number of
26
27 sharing partners during the week preceding the study and (3) number of sharing partners
28
29 during the month are preceding the study. Results evidenced significant differences
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31 between the three groups ($F(6, 182) = 4.17$; $p \leq 0.01$; $\eta_p^2 = 0.12$). ANCOVA results
32
33 showed that HIV/AIDS respondents had shared their illness-related emotions less
34
35 frequently ($F(2, 93) = 9.30$; $p < 0.01$; $\eta_p^2 = 0.17$) and with a lower number of partners
36
37 during the week preceding the study ($F(2, 93) = 8.49$; $p < 0.01$; $\eta_p^2 = 0.15$) when
38
39 compared to both the diabetes group and the cancer group (Post Hoc tests: $p < 0.01$).
40
41 They had also shared these illness-related emotions with a lower number of sharing
42
43 partners during the month preceding the study ($F(2, 93) = 10.96$; $p \leq 0.01$; $\eta_p^2 = 0.19$)
44
45 when compared to both comparison groups (Post Hoc tests: $p < 0.01$). Notably, no
46
47 significant differences were found between the three groups regarding the social sharing
48
49 of non-illness related emotions ($F(2, 93) = 1.75$; NS).

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51 Likewise, ANCOVA (co-variants: guilt, shame, diagnosis disclosure and time of
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53 diagnosis) results confirmed the group effect for the non-sharing of illness-related
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SOCIAL SHARING OF EMOTIONS IN HIV/AIDS

emotions ($F(2, 93) = 6.00; p \leq 0.01; \eta_p^2 = 0.11$). This analysis showed that the HIV/AIDS group scored significantly higher for the non-sharing of illness-related emotions when compared to the diabetes and to the cancer groups (Post Hoc tests: $p < 0.01$; See Table 2). The three groups were found at comparable levels as to their desire to share their illness-related emotions ($F(2, 93) = 1.99$; NS).

Social Integration

No significant differences were found between the three groups in the perception of social support and social integration ($F(2, 96) = 1.61$; NS) when controlling for diagnosis disclosure. As to perceived social exclusion, ANCOVA (co-variant: diagnosis disclosure) was carried out and yielded a significant group effect ($F(2, 96) = 6.12; p < 0.01; \eta_p^2 = 0.11$). Post Hoc tests ($p < 0.01$) showed that the HIV/AIDS group ($M = 1.68$; $SD = 1.02$) had significantly higher scores for perceived social exclusion when compared to the cancer group ($M = 1.06$; $SD = 0.21$).

Discussion

Chronic illness patients encounter inhibition and constraints in the social sharing of their illness-related emotions (Herbette & Rimé, 2004; Lepore & Revenson, 2007). Expressing one's suffering and disclosing one's life-threatening condition can elicit negative responses from healthy others. We hypothesized that among chronically ill patients, those suffering from HIV/AIDS would be particularly at risk of experiencing negative social responses. HIV/AIDS, involving stigmatizing information and a linkage to sexual behaviour, is most likely to be kept concealed (Kelly, 2002). *Furthermore, since HIV is a contagious disease, it represents a health threat to healthy others, therefore eliciting negative reactions (Bos et al., 2008).* We thus expected that compared to other patients suffering a chronic illness, HIV/AIDS patients would manifest a distinctive propensity of holding back their need to socially share their

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2
3 illness-related emotions. Our study comparing HIV/AIDS patients to diabetes and
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5 cancer patients yielded abundant support to these predictions.
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7 We found that HIV/AIDS patients rated their illness as less severe. In spite of
8
9 this, they were more concerned by other persons' negative perception of their illness
10
11 than did the comparison groups. They expressed a higher apprehension that disclosing
12
13 their illness experience would (1) reflect a negative image of them, (2) entail their social
14
15 rejection, and (3) expose them to a lack of discretion of their listeners. These results are
16
17 congruent with other studies evoked in the introduction showing HIV/AIDS patients to
18
19 fear others' negative responses. Such observations concur to expect that these multiple
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21 external threats perceived HIV/AIDS patients affect negatively their social sharing of
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23 illness-related emotions. Motives in this regard resulted from internal sources.
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25

26 HIV/AIDS patients differed markedly from the other two groups regarding illness-
27
28 related emotions: they manifested higher guilt and shame. Past research demonstrated
29
30 that shame, guilt and self-attribution of responsibility constitute as factors proper to
31
32 favor emotional secrecy (Kelly, 2002; Finkenauer & Rimé, 1998). Thus, altogether with
33
34 the social ones, these emotional and cognitive factors should concur in affecting
35
36 HIV/AIDS patients' sharing of their illness-related feelings.
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40 The expected consequences were largely supported by this study's findings.
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42 HIV/AIDS patients in this study disclosed their diagnosis much less than did cancer and
43
44 diabetes patients. Moreover, the direct assessment of the social sharing of illness-related
45
46 emotions revealed three remarkable facts. First, HIV/AIDS patients were perfectly
47
48 comparable to diabetes and cancer patients for their usual SSE unrelated to their illness.
49
50 They thus respond to the general principle of the SSE in the same way as do other
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52 people. Second, HIV/AIDS expressed as much need to share their illness-related
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54 emotions as the two comparison groups. They thus clearly want as much as other
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SOCIAL SHARING OF EMOTIONS IN HIV/AIDS

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3 chronic patients to share emotions resulting from their illness condition. Third, in sharp
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5 contrast with the two previous observations, HIV/AIDS patients differed markedly for
6
7 the social sharing of their illness-related emotions. They shared these emotions at a
8
9 much lower frequency and with a much lower number of persons. In sum, many
10
11 elements confirmed HIV/AIDS patients to experience a constrained sharing of their
12
13 illness experience. Thus, if a chronic illness exposes patients to social constraints and to
14
15 a contained sharing of illness-related emotions (Herbette & Rimé, 2004; Lepore &
16
17 Revenson, 2007), the present study revealed HIV/AIDS patients to be particularly
18
19 underprivileged in this regard.
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22
23 On the one hand, it was expected that as a result of the predicted non-sharing of
24
25 illness-related emotions, HIV/AIDS patients would experience more mental
26
27 ruminations, intrusive thoughts and search for meaning. A known paradoxical result of
28
29 the suppression of thoughts or feelings is the rebound effect. The very state of mind one
30
31 had thought to avoid, tends to impose itself forcefully thereafter (see Wentzlaff &
32
33 Wegner, 2000 for a review). However, this prediction was not supported. On the other
34
35 hand, the numerous social threats HIV/AIDS patients fear, together with the inhibited
36
37 sharing of their illness experience, supported the expectation that these patients would
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39 report reduced social support and lower social integration. This prediction was only
40
41 partially sustained. HIV/AIDS patients did not differ for perceived social support.
42
43 However, they rated themselves higher for social exclusion.
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47
48 How can we account for these partially negative findings with respect to our two
49
50 hypotheses? One possibility is that even if HIV/AIDS patients limit the sharing of their
51
52 illness-related emotions, they nevertheless find around themselves enough listening for
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54 their illness-related emotions. In this manner, they would avoid the cognitive
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56 consequences of a rebound effect likely to follow from a total lack of sharing. Finding
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SOCIAL SHARING OF EMOTIONS IN HIV/AIDS

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3 enough listening would also lead these patients to perceive the social support they
4
5 receive as relatively satisfactory. The socio-cultural context in which the present study
6
7 was conducted might play some role in this regard. In the Dominican Republic, family
8
9 ties are of particular importance. The family forms the basis of stability and the
10
11 individual derives a social network and assistance in times of need from the extended
12
13 family which generally encompasses three generations. Loyalty to the family comes
14
15 before any other social relationship. In such a socio-cultural context, it is possible that
16
17 HIV/AIDS patients receive more attention, help and support from their closer family
18
19 circle than would be the case in more individualistic cultures. Thus, the numerous
20
21 threats these patients perceive from the disclosure of their illness might regard their
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23 broader social network only and might thus be less consequential for the emotional,
24
25 cognitive and social variables examined here.
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30 Future studies might profitably compare the social situation of HIV/AIDS
31
32 patients across individualistic and communal socio-cultural contexts. Likewise, future
33
34 research can benefit from inter and intra disease comparisons regarding patients'
35
36 perceptions of negative social responses. For example, differences concerning diabetes
37
38 linked to obesity and diabetes mellitus, where causal and self-blame attributions can
39
40 vary. The same could be explored among different cancer diagnosis and treatments or
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42 among HIV/AIDS patients with different infection modes.
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46 Nonetheless, it still remains that HIV/AIDS patients in this study reported higher
47
48 feelings of social exclusion. Even if this would regard only their broader social circle,
49
50 HIV/AIDS patients might incur damaging consequences from such a situation. Previous
51
52 studies demonstrated that a lower social integration is associated with a higher mortality
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54 (Bekman & Syme, 1979; House et al., 1982). Social integration is considered a major
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56 risk factor for morbidity and mortality, and the level of risk involved was shown to
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SOCIAL SHARING OF EMOTIONS IN HIV/AIDS

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3 parallel those of classic health risk factors such as obesity, sedentarity, and perhaps
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5 smoking (House et al., 1988). Future studies should thus assess effects of interventions
6
7 focused upon the various emotions which were found to be distinctive for HIV/AIDS:
8
9 fear of social threats, shame, and guilt. In parallel, intervention programs should aim at
10
11 modifying the representation of HIV/AIDS among people living in geographic areas
12
13 with important concentrations of patients.
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Table 1. Age, sex, educational level, time of diagnosis and marital status per group.

VARIABLE	HIV/AIDS (n=35)	Diabetes (n=35)	Cancer (n=34)
AGE			
M	42.09	41.77	42.91
SD	11.24	11.27	12.00
SEX			
Male	45.71%	45.71%	41.18%
Female	54.29%	54.29%	58.82%
EDUCATIONAL LEVEL			
Elementary School	68.57%	77.14%	70.59%
High School	11.43%	14.29%	17.62%
Technical Degree	5.71%	5.71%	2.94%
University Degree	8.57%	0	2.94%
No Diploma	5.71%	2.86%	5.88%
TIME DIAGNOSIS			
≤ 10 years	80%	62.86%	97.06%
≥ 10 years	20%	37.14%	2.94%
MARITAL STATUS			
Single	54.29%	37.14%	37.14%
In a couple	45.71%	62.87%	35.29%

Note. Educational level refers to the last diploma obtained.

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Table 2. Mean, Standard Deviation, ANCOVA results for the variables involving the social sharing of illness-related emotions.

VARIABLE	GROUP	M(SD)	F(2,93)	p	η_p^2
Frequency of Emotion Sharing	HIV/AIDS (n=35)	1.83(1.27)**			
	Diabetes (n=35)	3.49(2.59)	9.30	≤0.01	0.17
	Cancer (n=34)	4.74(2.59)			
Number of Sharing Partners Past week	HIV/AIDS (n=35)	1.94(1.41)**			
	Diabetes (n=35)	3.54(2.39)	8.49	≤0.01	0.15
	Cancer (n=34)	4.91(2.30)			
Number of Sharing Partners Past Month	HIV/AIDS (n=35)	1.86(1.59)**			
	Diabetes (n=35)	4.60(3.29)	10.96	≤0.01	0.19
	Cancer (n=34)	6.29(3.24)			
Non-sharing of illness related emotions ($\alpha=0.88$)	HIV/AIDS (n=35)	4.13(1.25)**			
	Diabetes (n=35)	2.43(1.53)	6.00	≤0.01	0.11
	Cancer (n=34)	2.16(1.63)			
Desire to share illness-related emotions	HIV/AIDS (n=35)	1.94(1.59)			
	Diabetes (n=35)	2.60(1.79)	1.99	NS	NS
	Cancer (n=34)	2.62(1.66)			

**Post Hoc evidences significant differences between the HIV/AIDS group and both Cancer and Diabetes groups.