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Constructing Spirit-Level Interventions for African American Women Living with HIV

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Constructing Spirit-Level Interventions for African American Women Living with HIV

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Dedication

This dissertation is dedicated to my father and mother, Roy Gene and Glenn Ella Marie Runnels. My parents taught us many things, one of them being to never quit. This work was completed to honor my father and mother and the legacy of excellence they instilled in each of their children. I am thankful for their continued encouragement and support. They set an example of diligence, service, and commitment that has made me who I am and provided the foundation for me to complete this work. Thanks Momma and Daddy.

Honour thy father and mother; which is the first commandment with promise;
That it may be well with thee, and thou mayest live long on the earth.
Ephesians 6:2 (KJV)

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"Constructing Spirit-level Interventions for African American Women Living with HIV"

Ratonia Cheryl Runnels, PhD

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Supervisor: Elizabeth Pomeroy

African Americans are disproportionately affected by HIV comprising only 12% of the U.S. population but accounting for nearly 50% of all HIV cases (CDC, 2009). HIV surveillance data estimate that one in 30 Black women will be diagnosed with HIV during their lifetime. For many HIV positive African American women, treatment of HIV infection and the subsequent psychological stress is complicated by lack of resources and competing life priorities. These women also face additional challenges such as fear of disclosure and lack of adequate social support. The complexity of challenges faced by African American women who are HIV positive highlight the need to explore their preferred ways of coping. Studies show that minority women tend to utilize alternative coping strategies when faced with dual mental and physical health challenges. Spirituality has been found to have a direct relationship with cognitive and social functioning and inversely related to HIV symptoms among African American women. Psychosocial interventions are a key component to improved quality of life for women living with HIV and spirit-level interventions are shown to buffer psychosocial distress

experienced by HIV positive persons. This dissertation consists of three publishable quality articles that examine issues associated with the function of spirituality in HIV positive women. The first article offers a conceptual framework incorporating the health belief model and a discussion of Lazarus & Folkman's stress and coping model to examine theoretical frameworks for integrating spirituality into social work practice interventions for HIV positive women. The second article seeks to contribute new information to the literature on the spirituality in the lives of HIV positive women. This article will present data that identifies, defines, and describes various uses of spirituality as a coping mechanism. The article will also discuss historical factors that influence the use of religion and spirituality among African Americans. The third article of this dissertation reviews published spiritually oriented interventions and compare, contrast, and critique the various components, sample, and intervention methods to determine the applicability and replicability of these interventions as a basis for increasing treatment options for co-morbid African American women.

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CHAPTER 1: INTRODUCTION

PROBLEM STATEMENT

The integration of religion and spirituality into social work education and practice remains a contentious topic of debate. Both NASW and CSWE require curriculum that address these content areas. To date there has been little evidence on how teaching spirituality and religion content in accredited programs is enhancing practice. Several spiritual assessment tools have been developed for use in practice but remain obscure in literature and social work texts. Studies have shown that social workers employ spirituality in their practice, and provide religious guidance and spiritual interventions despite a lack of training in the area (Modesto, Weaver, & Flannelly, 2006). The inception of government policies such as Charitable Choice has demanded a greater breadth and depth of knowledge of faith-based initiatives as a community resource. Understanding spirituality and religious behavior in the context of the client system is crucial to the delivery of culturally competent practice.

Healthy People 2020 stipulates that all Americans receive culturally competent care to eliminate health disparities (U.S. Department of Health and Human Services, 2011). Spirituality and religious participation are common coping strategies for many Americans. Religious coping has been found particularly salient among people with less access to mainstream economic and social resources, offering them significant solutions to life problems. Additionally, research findings support the importance of spiritual coping for trauma survivors with co-occurring disorders and stress the value of increased attention to spirituality in behavioral health services, especially in assessment and

therapeutic relationships (Arnette, Mascaro, Santana, Davis, & Kaslow, 2007; Fallot & Heckman, 2005; Fowler & Hill, 2004; Gillum, Sullivan, & Bybee, 2006; Watlington & Murphy, 2006).

IMPORTANCE OF THE AREA OF INTEREST

Health disparities are well documented among persons of lower socioeconomic status and minority populations including African Americans, Native Americans, Asian Americans, and Latinos (Barr, 2008). When compared to Whites, these groups have higher incidence of chronic disease, higher mortality, and poorer health outcomes (Office of Minority Health, 2009). Economic factors, environmental factors, social structures, public health systems, and discrimination (Barr, 2008; Brach & Fraser, 2000; Williams & Collins, 2001; Williams, 1999) have been cited as contributors to health disparities among minority populations. African Americans in particular have shown significant delay in help seeking and significant delay in treatment initiation upon diagnosis (Smith, Adams, Das, Bottai, Fulton, & Hebert, 2008; Zerwic, Hwang, & Tucco, 2007). According to the 2005 National Healthcare Disparities Report, African Americans tended to have lower use of routine care, outpatient mental health care, and outpatient HIV care but higher use of emergency departments and hospitals, including higher rates of avoidable admissions, inpatient mental health care, and inpatient HIV care. The Office of Minority Health reports that in 2005, the death rate for African Americans was higher than Whites for heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, HIV/AIDS, and homicide. Black women are more likely than White women to report forgoing needed physician care. Preventable illnesses are in advanced stages at

initiation of treatment. Inconsistent medication adherence is also an issue, particularly among elderly African Americans.

There is evidence to support the argument that when people are sick they go to the doctor. However there continues to be notable disparities in health and mental health status among African Americans. Once African Americans are in care, treatment outcomes are fairly equal to those of other population groups. Therefore, it is important to analyze the sociocultural mediating factors that may influence when and how patients seek help. Numerous studies have illustrated the importance of spirituality in coping among African American women (Coleman, 2006; Dalmida, 2009; Scarinci, 2009). However, few studies have been conducted to provide empirical support explaining the mechanisms by which spirituality and religious participation act as coping strategies among this population. Much of the literature supports the connection between spirituality and health, identifying spirituality as a key construct for men and women affected by HIV (Szaflarski, 2006). Research findings also support the importance of spiritual coping for women trauma survivors with co-occurring disorders and stress the value of increased attention to spirituality in behavioral health services, especially in assessment and therapeutic relationships (Arnette, Mascaro, Santana, Davis, & Kaslow, 2007; Fallot & Heckman, 2005; Fowler & Hill, 2004; Gillum, Sullivan, & Bybee, 2006; Watlington & Murphy, 2006). Several empirical studies have been conducted to examine the relationship between religion and spirituality and health and well-being (Hackney & Sanders, 2003; Pardini, Plante, Sherman, & Stump, 2000; Rippentrop, Altamaier, Chen, Found, & Keffala, 2005). However, due to the complexities associated with defining and

measuring levels of spirituality and religiosity, research findings have been varied and sometimes vague, suggesting that even though the importance of spirituality is highlighted in the literature, the mechanisms by which it is employed have not been fully analyzed for incorporation into needed social and behavioral interventions.

Defining Spirituality

Budding interest in the concept of spirituality has generated an array of applicable definitions among social scientists. Although spirituality is a different concept than religion, the two concepts are inter-related (Hodge & McGrew, 2005; Hodge & McGrew, 2006). The Thesaurus of Psychological Index Terms (1991) defines spirituality as the "degree of involvement or state of awareness or devotion to a higher being or life philosophy…not always related to conventional religious beliefs" (as cited in Lukoff, 1998). Pargament and Mahoney (2002) argue that, for many, spirituality is the search to discover what is sacred, and that the journey can take either nontraditional avenues such as involvement in twelve-step groups, meditation, or retreat centers, or traditional pathways such as organized religions. One example of the relationship between spirituality and religion can be found in a study of social work students (N=88) associated with the National Association of Christian Social Workers (NACSW). In this study, Hodge and McGrew (2005) found multiple themes were used to define religion, with the most prominent being the practice of one's spirituality or faith.

Spirituality has been related in the literature to a person's search for a sense of meaning and morally fulfilling relationship between oneself, other people, the universe, and the metaphysical; or a search for the sacred (Pargament, 1997). The Random House

Dictionary (n.d.) defines the term sacred as "devoted or dedicated to a deity or to some religious purpose; consecrated". Pargament and Mahoney (2005) take a more integrated approach to view the sacred as inclusive of concepts of God, of the divine, and of transcendent reality. Studies have shown individuals' relationship or sense of connection to that which is sacred as a factor in the rendering of acts such as forgiveness and caregiving (Davis, Worthington, Hook, Tongeren, 2009; Faver, 2004). Faver (2004) reports on a church-based sample of caregivers that describe their connection to a sacred other as "an experience of sacred companionship in daily life" referring to a perceived relationship with God, expressed in sayings such as "God is everywhere with me", and described God as "walking beside me" (Faver, 2004). According to some traditions, holy places represent sacred sites or power-filled energy centers where visitors may experience a sense of unification with nature, a feeling of bliss, communication with other species, visions, memories, or ecstasies (Parra & Argibay, 2009). Swan (1988), in exploring sacred places in nature and transpersonal experiences, notes that plants, animals, and all forms of nature are seen by some as messages for spiritual images and information from a world beyond this one.

Understanding spirituality within the context of social work practice

The Council on Social Work Education (CSWE) Educational Policy 2.1.4 promotes diversity and difference in practice, listing religion as a dimension of diversity (CSWE Education Policy and Accreditation Standards, 2008). The National Association of Social Workers (NASW) Code of Social Work Ethics incorporates a religious component as part of a social worker's responsibilities, stating "Social workers also

should be aware of the impact on ethical decision making of their clients' and their own personal values and cultural and religious beliefs and practices." (NASW, Purpose of the NASW Code of Ethics, para. 6). Understanding spirituality is essential to understanding the culture of numerous ethnic groups that social workers help as religion and spirituality are reflected in a wide range of belief systems that clients could hold. There are many well known belief systems and some less known by social workers such as Christian fundamentalism, Orthodox Judaism, Catholic contemplative mysticism or liberation theology, Zen Buddhism, Native American spiritism, and new age religious eclecticism (Dudley & Helfgott, 1990). Social workers need to be prepared to deal with the spiritual and religious aspects of clients' experiences, as with any other aspects of those experiences. Without specific professional preparation to help clients with spiritual and religious matters, the social worker is not likely to respond effectively (Barker, 2007; Canda, 1989; Dudley & Helfgott, 1990; Furman, Benson, Grimwood, & Canda, 2005; Gilligan & Furness, 2005; Loewenberg, 1988).

The last twenty-five years have marked considerable research on factors related to religion and spirituality in a number of areas such as psychology, sociology, and nursing. More recently, with the increasing popularity of the strengths perspective and its emphasis on acknowledging patient attributes, strengths, worth, and potential, spirituality and religion have gained increased attention in the field of social work. Consequently, social workers are being called on more often to conduct spiritual assessments. Several empirical studies have been conducted to examine the relationship between religion and spirituality and health and well-being (Hackney & Sanders, 2003; Pardini, Plante,

Sherman, & Stump, 2000; Rippentrop, Altamaier, Chen, Found, & Keffala, 2005). However, due to the complexities associated with defining and measuring levels of spirituality and religiosity, research findings have been varied and sometimes vague. In a systematic review of religious and spiritual research in social work, Modesto, Weaver, and Flannely (2006) found that between 1995 and 2000 thirteen percent of quantitative studies published in six major social work journals measured at least one religious or spiritual variable. The largest proportion of studies focused on protective factors and coping behaviors associated with religion and spirituality.

LITERATURE REVIEW

The impact of religion and spirituality on health outcomes

Research has shown that spirituality can have a positive effect on physical and mental health. Across disciplines such as nursing, psychology, sociology, and even occupational therapy, levels of spirituality and religiosity have been linked to quality of life, health behaviors, coping, perceptions of social support, medication adherence, and substance use and treatment. Spirituality and religion are considered important aspects of care for patients with chronic illnesses. Serious illnesses like cancer and HIV may cause patients or family caregivers to have doubts about their beliefs or religious values and cause much spiritual distress. Holt, Lewellyn, and Rathweg (2005) conducted a qualitative study to examine the religiosity–health association among African Americans, with particular attention to mediators through which religiosity positively impacts health. The authors found strong support for spiritual health locus of control as a mediator, followed by religious coping (both health and non- health related), positive affect/mental

health, scriptural influence on health behavior and sense of meaning. Spiritual health locus of control involves the belief that a higher spiritual power (e.g. God) has control over one's health outcomes (Holt, Lewellyn, & Rathweg, 2005). This belief includes two dimensions- active spiritual health locus of control and passive spiritual health locus of control. An active belief reflects the idea that God empowers one to take care of him or herself. Passive spiritual health locus of control involves the belief that God controls one's health, regardless of what one does (Holt, Lewellyn, & Rathweg, 2005).

Some studies show that patients with chronic illness may feel that they are being punished by God or may have a loss of faith after being diagnosed (Holt, Lewellyn, & Rathweg, 2005; Pargament, McCarthy, Shah, Ano, Tarakeshwar, & Wachholtz, et al, 2004). Other patients may have mild feelings of spiritual distress when coping with serious and chronic illness. In a study to examine the role of spirituality in African American Christian women diagnosed with breast cancer, researchers found that among many of the participants, spirituality served as a coping resource upon learning of their diagnosis (Simon, Crowther, Higgerson, 2007). Many of the women expressed reduced levels of anxiety and fear and the feeling that spirituality had helped them find meaning in the situation. Furthermore, spirituality helped patients find a will to live. A longitudinal study of a nationally representative cohort of 2266 patients receiving care for HIV infection found that 85% of respondents reported a religious affiliation and that spirituality was "somewhat" or "very" important in their lives (Lorenz, Hays, Shapiro, Cleary, Asch, & Wenger, 2005). Another study of 275 HIV-infected individuals found that different dimensions of spirituality and religiosity were positively correlated with

coping and adapting (Somlai & Heckman, 2000). The study showed that those who utilized prayer, formal religion, and reported a higher sense of spirituality were more likely to use adaptive coping strategies. Recent research among people with HIV also suggests that those who find meaning through spirituality suffer less from emotional distress, anxiety and depression and are able to cultivate a greater sense of hope for the future than those who do not (CIRA, 2009). Additionally, spiritual coping has been associated with higher immune function.

Nursing and psychology fields have recognized spirituality as a critical component of individual well-being for decades. Most prominent is Abraham Maslow's hierarchy of need which included a spiritual component in the construct of self-actualization (Powers, 2005). More recently, with the increasing popularity of the "strengths perspective" and its emphasis on acknowledging patient attributes, strengths, worth, and potential, spirituality and religion have gained increased attention. A familiar movement incorporating the use of spiritual concepts in the treatment and recovery of substance abuse and dependence is that of Alcoholics Anonymous (AA). AA and its counterpart, Narcotics Anonymous (NA) are self-help 12-step programs that view drug and alcohol dependence as a multifaceted problem affecting physical, mental, and spiritual arenas. One major tenet of this process-oriented treatment and recovery plan is submission to a higher power. AA does not subscribe to any particular religious or spiritual ideology but leaves interpretation and definition of the concept "higher power" to the individual, allowing its tenets to be embraced by diverse populations and cultures. Other treatments have risen to combat substance use and promote HIV prevention such as

Spiritual Self-Schema (3-S) therapy (Margolin, Beitel, Schuman-Oliver, & Avants, 2006). Integrating Buddhist and cognitive psychologies, 3-S therapy is based on the premise that motivation for HIV prevention and sobriety can be increased by drawing on the clients' spiritual beliefs and religious faith. Studies found 3-S therapy to be efficacious in community substance abuse treatment programs and with clients of all faiths. Due to the complexities associated with defining and measuring levels of spirituality and religiosity, research has been limited. Notwithstanding, several empirical studies have been conducted to examine the relationship between religion and spirituality and health and well-being (Hackney & Sanders, 2003; Pardini, Plante, Sherman, & Stump, 2000; Rippentrop, Altamaier, Chen, Found, & Keffala, 2005).

Conceptual Framework

The rich historical and spiritual traditions common in African American communities provide scaffolding for the incorporation of spirit-level interventions into mental health services. Religious and spiritual orientations among African Americans have been used to deal with suffering and construct meaning of oppression throughout history (Mattis & Jagers, 2001). In concert with Bent-Goodley and Fowler's (2006) definition of spirituality as a comprehensive response to challenges and stressors of individuals and communities through their natural support networks and inner strength, the African American church is one of the few resources that have been consistently present and tapped as a viable resource (Cook & Wiley, 2000) and support network. The church is often seen as a source of empowerment and strength for many African Americans, with African American women playing a critical role in its survival and

sustainability (Musgrave, Allen, & Allen, 2002). The "Black church" often assists African American women with maintaining their mental health by providing a therapeutic community that allows for articulating suffering, finding collective support, providing an asylum to release frustrations and pain without judgment, typically expressed through emotionalism, and validation of Black women's experiences in America (Brome, Owens, Allen, & Vevaina, 2002). Furthermore, African Americans' reliance on clergy has been viewed as a reflection of their perception that African American clergy can identify and emphasize more culturally relevant care than psychotherapists (El-Khoury, Dutton et al. 2004).

African Americans are also disproportionately affected by HIV, comprising only 12% of the U.S. population but accounting for nearly 50% of all HIV cases (CDC, 2009). African American women have been greatly impacted by the HIV/AIDS epidemic. The rate of new HIV infections among Black women in 2006 was 15 times that of white women and four times that of Hispanic women (Centers for Disease Control and Prevention, 2009). HIV surveillance data estimate that one in 30 Black women will be diagnosed with HIV during their lifetime. The high prevalence of Human Immunodeficiency Virus (HIV) among African American women underscores the need for attention to interventions focusing on mental health issues within this population. The high rates of co-occurring disorders among persons with HIV indicate the need for mental health services as a key component of HIV care (Health Resources and Services Administration, 2004). Empirical data has also highlighted the need for screening and treatment for co-occurring mental health and substance use problems among HIV-

positive patients as a necessary component to improving adherence to antiretroviral medications (Lucas, Gebo, Chaisson, & Moore, 2002; Tucker, Burnam, Sherbourne, Kung, & Gifford, 2003).

This study attempts to describe how HIV positive African American women use spirituality to cope with psychological stressors resulting from HIV infection utilizing an integrated modified version of the Health Belief Model (Rosenstock, 1974) and Lazarus and Folkman's transactional theory of stress, appraisal, and coping. The transactional stress theory (Lazarus & Folkman, 1984) postulates that social support is identified as a resource influencing the cognitive appraisal of stressful encounters. Coping is one result of this cognitive appraisal, and is mediated by the existence of social support. According to this theory, resources influence coping, and coping produces various outcomes. Lazarus and Folkman (1984) describe coping as the cognitive and behavioral efforts employed to manage "the demands of the person-environment relationship that are appraised as stressful and the emotions they generate" (p. 19) (see Figure 1.1).

The health belief model depicts the association between an individual's behavior and the positive or negative evaluation of that behavior and its outcomes. The model consists of four dimensions, including (a) perceived susceptibility to illness; (b) perceived illness severity; (c) perceived benefits of treatment; and (d) perceived barriers to treatment compliance (see Figure 1.2). The health belief model also postulates that diverse demographic, psychosocial, and psychological variables may affect individuals' perceptions and thereby indirectly influence health-related behaviors. Coping is an important construct in mental health research and practice, therefore its role in the lives

of HIV positive women requires greater understanding. In this study, the conceptual model of coping recognizes HIV infection as a specific type of stress, which can result in mental health problems such as depression and anxiety (see Figure 1.3).

Within the context of this framework, several theories are presented that encompass the constructs of spirituality and culture, and lend themselves to the discussion of perspective, interpretation, patterns, and internalized beliefs (See Figure 1.4). To emphasize their relevance to the practice of social work, these concepts can be viewed through the lens of a strengths perspective. The strengths perspective requires that individuals, families, and communities be viewed in light of their talents, competencies, possibilities, and values even in the face of oppression or trauma (Saleebey, 1996). Differences in power and resources, characterized by variables such as race, socioeconomic status, and gender, can influence an individual's perception and interpretation of reality. Using the strengths perspective, the social worker is required to investigate, compile, and utilize existing resources within the individual, family, and community systems. In an effort to magnify the resurgence of interest in spirituality in social work and other social sciences, several authors have highlighted the protective factors of spirituality for minority and marginalized populations, women, and under-served communities (Barker, 2007, Canda, 1989; Dudley & Helfgott, 1990; Gilligan & Furness, 2005; Sheridan, Wilmer & Atcheson, 1994; Sheridan & Hemert, 1999).

Constructivist theories are offered to provide an over-arching conceptualization of the idea that individuals are creators of their own realities. Symbolic interaction theory is also discussed as an aid to social workers in understanding the culturally different

interpretations of social experiences. Accordingly, resilience theory has emerged as a clarifier of spirituality within the strengths perspective, identifying the process in which the development of substantive character is made up of periods of disruption and the development and use competencies in life management (Greene, 2003). Whereas resilience can be categorized as strength, transformational learning theory addresses the progressive nature of the coping process. There is agreement among the fore mentioned theories that individual perspective, interpretation, patterns, and internalized beliefs are guided by a search for meaning and connection and influenced by interaction with others.

Research Question and Methodology

The purpose of this research is to conduct a content analysis of interview data from HIV positive African American women to explore and analyze themes related to the function and impact of spirituality in coping behaviors and health and mental health maintenance. Information gathered from this study will benefit multiple arenas including public health and mental health services studies in developing theoretical frameworks for addressing the multi-faceted aspects of the impact of HIV/AIDS. Uncovering the foundational structures of spiritual and social support networks in HIV positive women will inform the development of culturally relevant intervention studies and current community practice.

This study will use content analysis to analyze interview data collected to assess the lived experience of HIV positive African American women in (southern state). Content analysis is a research tool used to determine the presence of certain words or concepts within texts or sets of texts. This methodology consists of quantifying and

analyzing the presence, meanings and relationships of such words and concepts, then making inferences about the messages within the texts, the writer(s), the audience, and even the culture and time of which these are a part. Although content analysis in qualitative research is not stringently defined (Hsieh & Shannon, 2005), for the purposes of this study, qualitative content analysis is defined as the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns.

This study will perform secondary data analysis on a previous study. The purpose of the original study was to give voice to HIV positive African American women living in (southern state) (P.I. ---). The main research questions for this study were (1) how did women living in (southern state) discover they were infected with HIV?; and (2) what are the lived experiences of women living with HIV in (southern state)?

The study followed a modified version of the grounded theory theoretical framework and served as a needs assessment pilot study. Thirty-four African American women who live in (southern state) Public Health Region 3 were recruited for the study. The participants had to be HIV positive for at least one year and were ages 25+. Participants were recruited from several health agencies that provide services to women who are HIV positive. Interviews were conducted over the span of 6-months and were recorded using an audio digital recorder. The study was approved by the --- Institutional Review Board. Member checking was conducted in the original study to ensure the rigor of the analysis. Although member checking is not an option for the secondary analysis, the principal investigator of the original study will act in a supervisory role to oversee the

analysis and use of the data. For the current study, a sample of fifteen interviews was analyzed. Whereas the original study used a grounded theory approach which allowed the researcher to create thematic codes in real time as data are collected, transcribed, and analyzed, the proposed study will utilize content analysis to explore themes related to the role of spirituality and social support and help-seeking behavior. Analysis of the qualitative data can help to identify the mechanisms by which spirituality and social support impact quality of life for HIV positive women and inform the design and development of interventions that provide necessary health and mental health services to this population.

Components of the dissertation as articles

This dissertation will consist of three publishable quality articles that examine spirituality as a coping mechanism in HIV positive women.

ARTICLE ONE: CONCEPTUAL AND THEORETICAL FRAMEWORKS FOR INTEGRATING SPIRITUALITY INTO PRACTICE INTERVENTIONS FOR HIV POSITIVE WOMEN

The intersection of spirituality and culture is explored to identify conceptual and theoretical frameworks that provide foundational support for integrating spirituality into practice interventions for HIV positive women, with particular focus on African American women living with HIV. This article presents relevant theory within the context of an integrated modified version of the Health Belief Model and Lazarus and Folkman's transactional theory of stress, appraisal, and coping. An Africentric approach to Maslow's hierarchy of needs is also introduced. Implications for social work practice and education will be discussed.

Targeted journal**:** Mental Health, Religion, and Culture

ARTICLE TWO: IDENTIFYING SPIRITUAL SUPPORTS IN AFRICAN-AMERICAN HIV POSITIVE WOMEN

This article seeks to contribute new information to the literature on the spirituality in the lives of HIV positive women by presenting qualitative data that identifies, defines, and describes various uses of spirituality as a coping mechanism. This study performed a secondary analysis of interview data previously collected to assess the lived experience of HIV positive African American women. Transcripts were coded by reading the transcripts and highlighting all text that on first impression appear to represent an expression or experience of spiritual or social support. Core elements of the interviews revealed God as an attachment figure, faith in God as a coping resource, and family as a support network, above church attendance for many of the participants. Implications for social work practice are also discussed.

Targeted journal: Qualitative Health Research

ARTICLE THREE: CRITICAL COMPONENTS: A REVIEW OF INTERVENTIONS DESIGNED FOR CO-MORBID HIV POSITIVE WOMEN

This article reviews relevant psychosocial interventions and describes their components and effectiveness. The article also examines interventions that do not overtly designate spiritual coping as an outcome, to identify components embedded within the interventions that may address spirituality and coping for co-morbid African American women. Findings report the applicability and replicability of the interventions in order to increase treatment options for co-morbid African American women.

Targeted journal**:** Journal of HIV/AIDS and Social Services

Figure 1.1: Stress and Coping Model

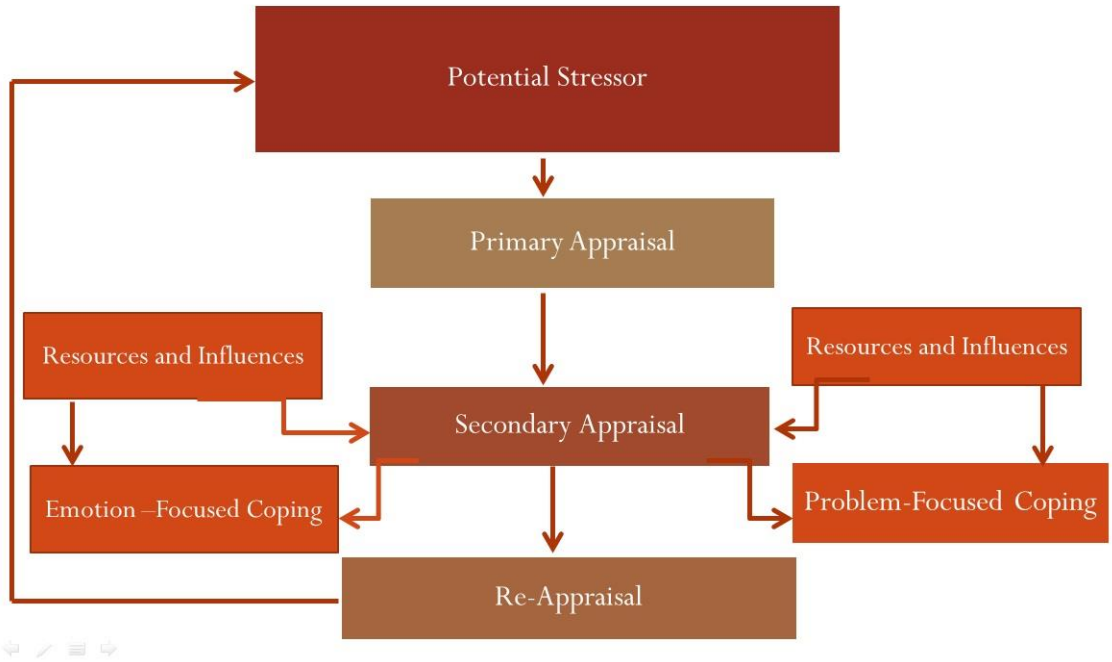


Figure 1.2: Health Belief Model

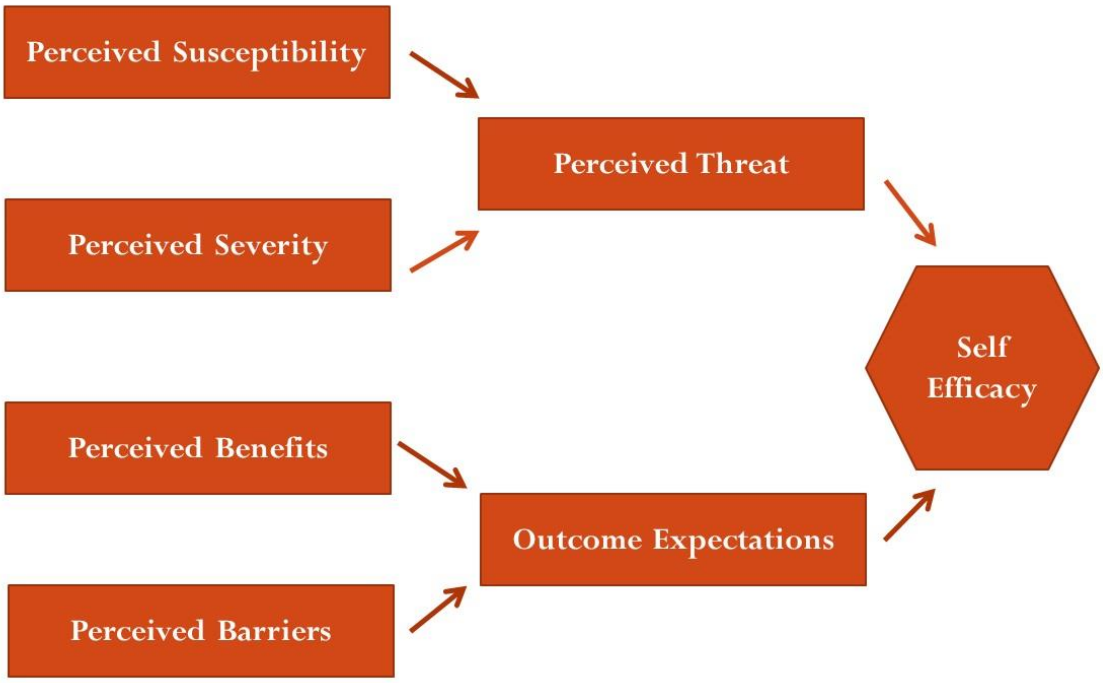


Figure 1.3: Integrated Modified Model of Coping

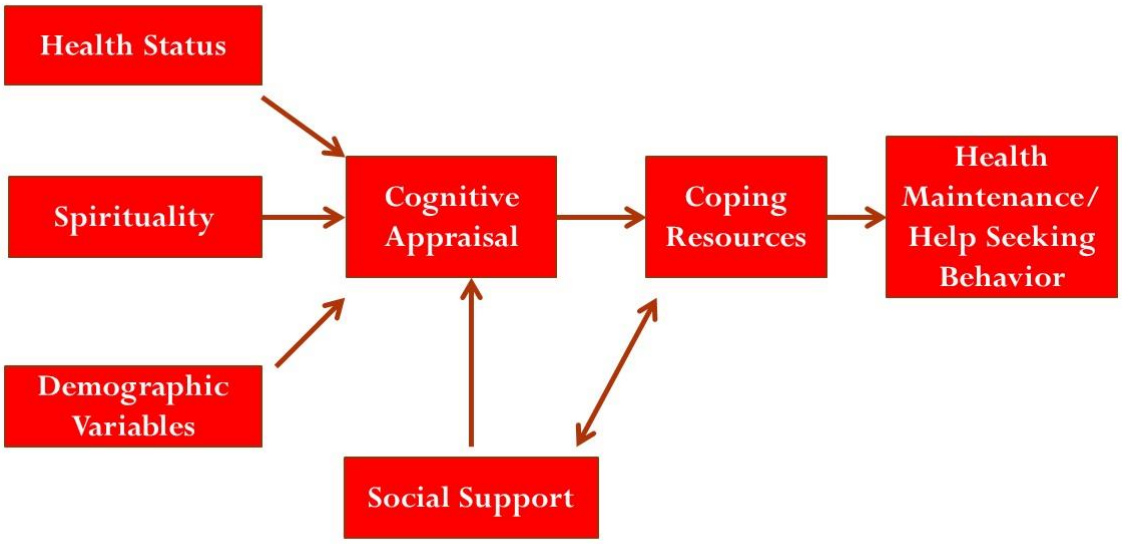
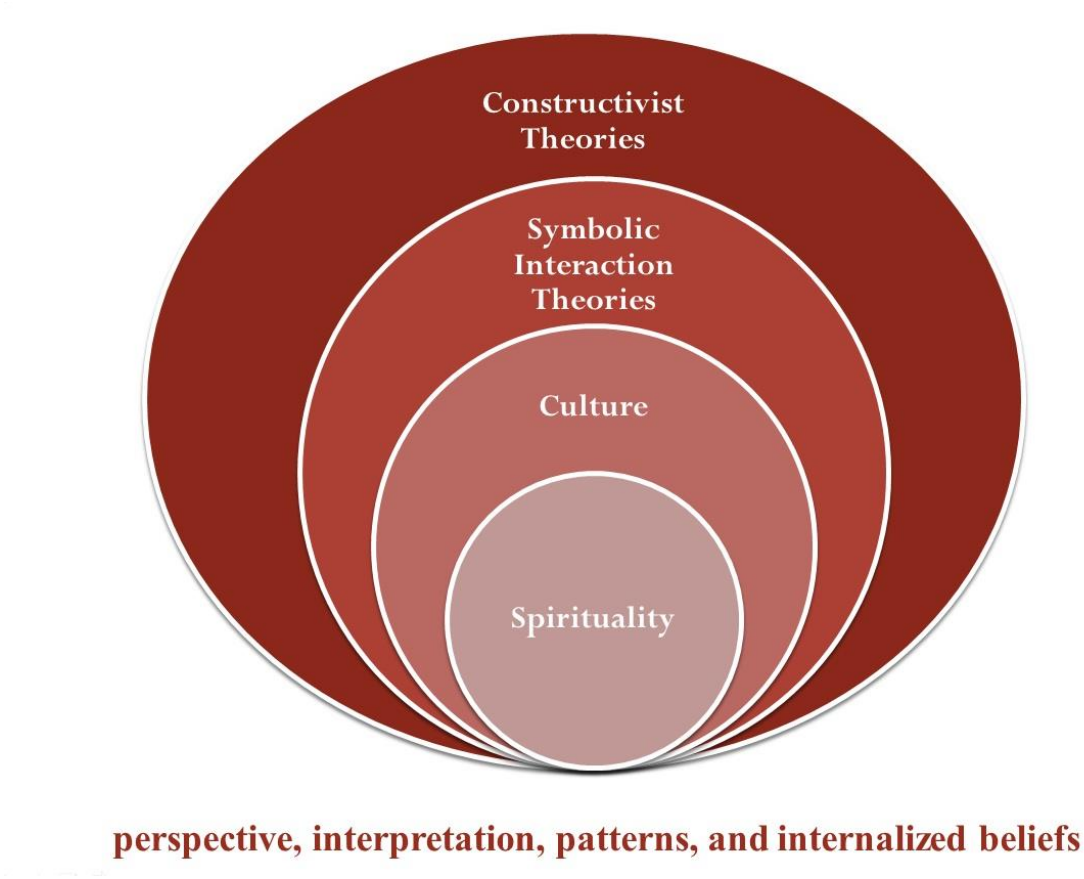


Figure 1.4: Theoretical Framework



CHAPTER 2: CONCEPTUAL AND THEORETICAL FRAMEWORKS FOR INTEGRATING SPIRITUALITY INTO PRACTICE INTERVENTIONS FOR HIV POSITIVE WOMEN

Currently, there is limited discourse on religious practice and expressions of spiritual awareness in social work practice. The discussion of religious matters in relation to personal and professional behaviors is often difficult for social workers and clients alike, due to valued and powerful allegiances to beliefs, social networks, families, and communities. Examining decisions and actions guided by faith principles and religious beliefs can provide some explanation for personal motivations. Therefore, critical thinking on these topics must occur at the access or community level, where contributing factors and outcomes can be observed and measured. Significant contributions have been made to the body of literature extracting the relationship between religion, spirituality, health, and mental health (Koening, 2012; Ellison & Fan, 2007; Pargament, McCarthy, Shah, Ano, Tarakeshwar, Wachholtz, et al., 2004; Chatters, 2000; Pargament 1997). However, the effects of spirituality and religious practice on cultural and social norms have not been fully explored with respect to racial/ethnic groups.

Among African American women, spirituality and religion are a common form of coping and many women often use prayer and spirituality as coping mechanisms and rely on their faith community for social support. Moreover, African Americans are 5 times more likely to use spiritual strategies to cope with illnesses or chronic conditions than with problems unrelated to health (Ellison & Taylor, 1996). Studies have suggested that increased spirituality among African Americans is directly related to fewer depressive symptoms (Ellison, 1995), higher self-esteem (Ellison, 1993), and higher life satisfaction

(Levin, Chatters, & Taylor, 1995). Spirituality has also been identified as a factor in an increased number of health-promoting behaviors in African American women such as diet, exercise, and recovery from substance abuse issues (Banks-Wallace & Parks, 2004; Lewis, 2004; Yanek, Becker, Mory, Gittelsohn,& Koffman, 2001).

Human Immunodeficiency Virus (HIV) surveillance data estimate that one in 30 Black women will be diagnosed with HIV during their lifetime, with the rate of new HIV infections among Black women being 15 times that of white women and four times that of Hispanic women (Centers for Disease Control and Prevention, 2009). Among African American women, spirituality has been found to have a direct relationship with cognitive and social functioning and inversely related to HIV symptoms. This article will offer and identify conceptual and theoretical frameworks for integrating spirituality into practice interventions for HIV positive women, with particular focus on African American women living with HIV.

Defining Religion and Spirituality

Research on the development of conceptual definitions of religion and religious involvement indicate that it is a multidimensional construct (Hodge & McGrew, 2005; Modesto, Weaver, & Flannelly, 2006; Pargament, 1997; Seybold & Hill, 2001). One of the most difficult and perplexing issues in the field concerns what is meant by religion and basic conceptual definitions of what constitutes religious involvement. Definitions of religion incorporate themes of both substantive content (e.g. beliefs, practices, and feelings directed toward God) and the functional aspects (e.g. a process focused on questions of ultimate meaning and concern) of religion (Chatters, 2000). Religion has

been defined as an organized system of beliefs, practices, rituals and symbols designed to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality), and to foster an understanding of one's relation and responsibility to others living together in a community (Cohen, Thomas, & Williamson, 2008; King & Crowther, 2004).

Pargament and Mahoney (2009) dissect the concept of spirituality by placing emphasis on the process of spirituality rather than on any particular concrete representations. The terms that the authors use to define spirituality, a "search" for the "sacred", implies process. This process has been identified as one of discovery, conservation, and transformation (Pargament & Mahoney, 2009). The pathways to discover that which is deemed sacred, efforts to hold onto the sacred, and attempts to transform the sacred when necessary, are diverse. For many, the process of achieving connection to the sacred involves the assignment of divine significance to time, objects and spaces. Pargament and Mahoney (2009) list several examples of objects viewed as sacred, including holy days; churches; events and transitions such as birth and death; cultural products characteristic of music and literature; people in leadership; psychological and social attributes such as self, compassion, and community; and roles, i.e. marriage, parenting, and work. Using these descriptors, a person seeking to find, know, and experience that which they perceive as sacred would be considered "spiritual" (Pargament & Mahoney, 2009).

Over the years feminist scholars have constructed models of psychological, moral, and spiritual developments that make relationships the central focus. In doing so Carol

Ochs (1997) analyzed the role of spirituality in caregiving, emphasizing relationships, connectedness, and love in spiritual development. Her model has been referred to as "relational spirituality" (Faver, 2004). The central feature of relational spirituality is the "insight of interconnectedness", which is the understanding that we are all connected to everything (Ochs, 1997). She proposes that coming into relationship with reality allows interdependent individuals to recognize the need for other people whose perspectives complement, challenge, and expand their own. According to these theories, the inherent relational nature requires social support and strengthening of the spiritual self to achieve optimum mental and physical balance; i.e. health.

FOWLER'S STAGES OF FAITH DEVELOPMENT

All people, consciously or unconsciously, live by faith to find meaning and order in their lives (Tam, 1996). According to Fowler (1997), some people put their faith in the transcendent value they call God; for those with no religion, these transcendent values may be love, justice, peace, or equality. In terms of growth and maturing in faith, every person, whether Christian or not, needs help. Fowler, a Christian professor of theology, attempted to make his theory applicable to persons of all beliefs, whether religious or nonreligious. Fowler defined faith as "the pattern of relatedness to self, others, and our world in light of our relatedness to ultimacy". The concept of ultimacy refers to whatever a person understands as the ultimate or most profound basis of reality that gives orientation to her or his life. This can be theistic, agnostic, or atheistic, thereby characterizing faith as an integral process underlying the formation of beliefs, values, and meanings. Fowler's theory has merit in its similarity to Pargament's conceptualization of

spirituality as a search for meaning; however, each stage denotes a linear process that relies on hierarchical categorizations that do not allow for more holistic interpretations of being that may represent faith or objects and experiences to which faith may be applied.

In this vein, a stage of faith is viewed as a pervasive pattern of knowing and valuing that orients us to ourselves, the world, and ultimacy. According to Fowler, transition through stages is affected by challenges to the prevailing faith orientation that require more complex, sophisticated, and comprehensive understandings. Fowler also suggested that change can be stimulated by "unpredictable and disruptive manifestations of God's grace" that can cause people to fundamentally re-evaluate their lives. Reflecting on Pargament & Mahoney's description of spirituality as process (2005), this can also be interpreted as spiritual struggles that result in greater effort to conserve the relationship to the sacred as well as attempts at transformation to re-affirm an individual's identity in relation to the sacred. Accordingly, the mechanisms employed to facilitate the search for the sacred will be determined by individual culture.

The intersection of spirituality and culture

The definition of culture is not static. Culture refers to the "organized pattern of values, beliefs, and behaviors developed and transmitted over time by a social group (Robbins, et al., 2006, p.130)." It is learned through social interactions and it is acquired through the organization of ideas, habits and conditioned emotional responses. Nagai (2007) defines culture as constructively created behaviors based on collective beliefs. Culture has been acknowledged among sociologists as a pattern of meanings that embody symbols which are historically transmitted (Olafsdottir & Pescosolido, 2009). This

definition follows the vein of Clifford Geertz (1973) who argued that meanings are not "in people's heads" but that symbols and meanings are shared between social actors. Geertz contends that cultural systems are ideational, and cultural patterns are not reified or metaphysical, but real things of this world, and to study culture is to study shared codes of meaning. Snibbe and Markus (2007) concluded that cultural models are sets of assumptions that are widely shared by a group of people, existing both in individual minds, public artifacts, institutions, and practices. Cohen & Hill (2007) agree that people who share religious identity can be meaningfully viewed as sharing cultural models.

The notion of logotherapy, developed by Viktor Frankl (1961), is based on the premise that the primary motivational force of an individual is to find a meaning in life. According to Viktor Frankl, we can discover meaning in life in three different ways: (1) by doing a deed; (2) by experiencing a value – nature, a work of art, another person, i.e., love; and (3) by suffering. The meaning and value that individuals place on deeds, actions, relationship, and existential concepts like suffering are influenced by what has been defined as "culture". Culture prescribes the nature and context of the relationship between the individual and life experiences. Culture will also prescribe the language used to define that relationship based on shared meanings and beliefs. Concepts used to define culture include beliefs and practices that develop based on personal values, and an organized pattern of beliefs and behaviors that are learned through social interactions and constructively created based on collective beliefs.

Suitably, the expression of spirituality can vary among different racial and ethnic groups. For example, Africentric spirituality may contrast Eurocentric spiritual

expression while sharing some attributes with Native American spirituality. There is a basic assumption that an Africentric perspective encourages an emphasis on sharing, cooperation and social responsibility, is not vested in any one religious tradition neither does it imply that one is powerless in the face of other forces (Schiele 1996; Stewart 2004; Adeleke 2005; Cokley 2005; Patton 2006). Africentricity is seen as a tool for community development, as opposed to personal enrichment which has been associated with a more Eurocentric perspective. Whereas a Eurocentric worldview is essentially materialistic, individualistic, and competitive, the Africentric worldview is described as one that embodies continuity between the spiritual and the material world, in which there is no separation between the sacred and the profane (Pullman, 1995). Africentric spirituality has been defined as a vital life force that connects humans to the universe, nature, the ancestors, and the community; that invisible universal substance that connects all human beings to each other and to a Creator or a Supreme Being (Schiele, 1996; Wheeler, Ampadu, & Wangari, 2002). While African spirituality represents a direct connectedness with nature, the universe, and spiritual forces of the African ancestry, we must acknowledge that much of African-American spirituality is expressed within the context of Judeo-Christian beliefs. Mazama (2002) contends that Blacks should abandon Western ideologies about Christianity arguing that the re-establishment of African spirituality plays a central role in Africentric philosophy. However, this could result in a harmful disruption as religious involvement is a source of cultural pride and social support for many African American women.

AN ADAPTATION TO MASLOW'S HIERARCHY OF NEEDS FOR SPIRIT-ORIENTED WOMEN

According to psychologist Abraham Maslow's hierarchy of needs, the construct of self- actualization would represent the highest spiritual dimension, the peak to be attained after basic survival needs, safety and security, love and acceptance, and esteem needs. To view Maslow's hierarchy from a spiritual orientation basic survival needs would be encompassed within basic spiritual needs. Figure 2.1 offers an alternative illustration of Maslow's hierarchy of needs from a spiritual perspective.

Within the context of spirituality, rather than basic survival needs, the base represents the knowledge or acceptance that one is connected to something other than or greater than themselves. The second level can be conceptualized as knowledge of the transcendental or existential being or connection that will spur a relationship. Characteristics of that relationship are formed. The greater being or cause will take on attributes such as provider, protector, giver, or reciprocator. This second level builds on the base in that the expectant relationship cannot be formed without the awareness and experience of connection to something greater than the self. The very state of being a spiritual person comes with expectations of safety, security, and reciprocity. Identity is molded within the perceived safety of this relationship. The middle levels imply that love and respect for self and others will spring from the relationship built in levels one and two. A spiritual person will seek to imitate and reciprocate the unconditional love and security experienced within the spiritual relationships. At this point, courage is gained to act on her beliefs and model ideal behaviors and attitudes toward life. The journey culminates at the peak, where self-actualization can be framed as purpose.

Many people face real life crises stimulated by lost spiritual connections with themselves and their cultural roots. A reconnection with similar elements of spirituality can restore a proper inner balance, permitting a reorienting to outer life and a more enhanced sense of self. For many women, spirituality penetrates every area of their lives and is typically developing from early childhood throughout adulthood. Their roles have been defined and subsequently accepted based on norms of religious affiliation and/or denomination. This affects the self-efficacy, their sense of worth, their sense of entitlement, as well as a sense of obligation and duty to those around them. For example, a woman may depend on God or the Creator to supply her basic needs, security, and to provide love and acceptance. Another may believe that love and acceptance of others reciprocates security and a promise of protection and meeting her basic needs. Still another may only perceive self-actualization and finding her meaning in life in terms of service and fulfilling her obligation to others, thus actualizing her ultimate purpose of connectedness to her community. The introduction of spirit in human development invites a cyclical interdependent function of basic needs. A diagram of what this process may look like is provided in Figure 2.2.

Figure 2.2 embodies the fore mentioned feminist construction of relational spirituality (Ochs, 1997). The interdependency displayed in the model depicts a reciprocal relationship between the elements of need that Maslow suggested exist within a hierarchy. Figure 3 bodes well to represent the individual who is self-actualized and finds her meaning and purpose in life by serving and fulfilling her obligation to others, relying on the security and reciprocity resulting from connectedness to her community. Interconnectedness, or understanding that we are all connected to everything, is central to relational spirituality (Ochs, 1997). From this perspective, growth, process, and self-actualization are embedded in the balance and maintenance of interdependent relationships. Application of this model to women in general and African American women in particular is critical due to the multiple roles and tasks many women must fill. When complex life circumstances are compounded with a chronic mental or physical illness, social support and viable social networks are crucial to maintaining optimum health.

These conceptualizations depict how some definitions of spirituality are consistent with a social constructivist perspective in which individuals are creators of their own realities based on observation and application of their experiences to the world. Individuals create patterns which they then attempt to fit or classify by experience. Even though the fit may not be perfect, the individual will attempt to make the experience conform to the patterns, which are based in prior experiences. These patterns of thinking aid to explain the reliance on faith in religious community and doctrine. Core beliefs that serve to develop personal identity also provide a personal schema of religious ideals,

purposes, and functions. Challenging life events such as death or illness can be evaluated and classified based upon pre-assigned meanings imposed by such schema. How these events are classified will determine a person's selected ways of coping.

Theoretical Overview

Coping is an important construct in mental health research and practice, therefore, its role in the lives of HIV positive women requires greater understanding. To describe how HIV positive African American women use spirituality to cope with psychological stressors resulting from HIV infection, theories presented in this article are applied within the context of an integrated modified version of the Health Belief Model and Lazarus and Folkman's transactional theory of stress, appraisal, and coping. The health belief model describes the association between an individual's behavior and the positive or negative evaluation of that behavior and its outcome, asserting that diverse demographic, psychosocial, and psychological variables may affect individuals' perceptions and thereby indirectly influence health-related behaviors. The transactional stress theory (Lazarus & Folkman, 1984) recognizes social support as a resource influencing the cognitive appraisal of stressful encounters. According to Lazarus and Folkman (1984) coping is a result of cognitive appraisal and mediated by the existence of social support. Coping responses include all cognitive and behavioral strategies used by individuals to manage a stressful situation; its two major functions being management of emotional distress and management of those problems causing psychological stress. Stress theory proposes that the effectiveness of any one coping strategy is dependent upon the match between the strategy and what is needed in the situation (Lazarus & Folkman, 1984).

In this study, the conceptual model of coping recognizes HIV infection as a specific type of stress, which can result in mental health problems such as depression and anxiety. Several theoretical concepts are proposed to demonstrate the relationships between social interaction, belief, and coping within the context of illness. The concepts are presented under the arc of social cognitive theory and include components of Attachment theory, Resiliency theory, and Transformational Learning theory. Symbolic interaction theory provides a capsule in which to envelope to this theoretical framework. Its focus on the relationship between the individual and society as it is reflected in the self sensitizes us (social workers) to the social aspect of development. Symbolic interaction theory addresses spiritual concerns through the social construction of meaning by which social and interactional processes contribute to human development and self-conception, and is based on the premise that identity involves shared significant symbols (or shared meanings) that emerge in the process of interaction with others. Viewing human behavior as rational, active, creative, and purposeful, symbolic interaction rejects the idea of an objective reality and points, instead, to the social construction of norms, and meaning that people assign to external phenomena (Robbins, Chatterjee, & Canda, 2006).

Social Cognitive Theory (SCT) acknowledges the reciprocal relationship between an individual's cognition, environment, and behavior (Bandura, 1994). Using social cognitive theory, Bandura (1994) put forward a conceptual model that serves to impact psychosocial factors through the exercise of control over behaviors that enhance or impair health. To accomplish this, Bandura rendered four major components to address cognition, environment, and behavior in the HIV infected and affected individual which

include an informational component, development of the social and self-regulative skills, building resilient self-efficacy, and creating social supports for desired personal changes. Through this lens, religiosity and spirituality influences each of the four components, both interchangeably, and simultaneously. When applied to HIV positive persons, the fundamental beliefs by which they govern themselves will either directly or indirectly influence perceived coping self-efficacy, which can affect immune function.

ATTACHMENT THEORY

Attachment theory, originally developed by Bowlby (1969) as an alternative to object relations theory, postulates that infants are predisposed to maintain closeness to its mother, and that this system of attachment is active and influential throughout the lifespan. The central focus of the theory is on the relationship between the infant and his or her primary caregiver or attachment figure that provides safety, comfort, and security. Ainsworth (1985) introduced the possibility of a surrogate or substitute figure to whom the child may be attached. Kirkpatrick and Shaver's (1990) original study argue that for many people, God may be the ideal "substitute" attachment figure. They found that beliefs about God and having a personal relationship with God can be predicted from the interaction of childhood attachment classification and parental religiousness. These results suggested that God may serve as a substitute attachment figure. Several studies have been conducted to measure the relationship between attachment to God and psychological distress (Ellison, Bradshaw, Kuyel, & Marcum, 2012; Bradshaw, Ellison, Marcum, 2010; Cicirelli, 2004; Beck &b Macdonald, 2004; Sim & Loh, 2003). Religious coping has been found particularly salient among people with less access to mainstream

economic and social resources, offering them significant solutions to life problems. Noticeably, much of the research conducted in this area has been narrowly focused on Christian, theistic religion. This works as an advantage for the purpose of this article due the prominence of historical Christian belief in African American culture.

Religiosity and spirituality play a role in self-concept and its effect on perceptions of chronic illness and subsequent actions or reactions. Attachment theory can be used to describe the development of self-concept and its role in event classification and subsequent selection of appropriate coping mechanisms. People who subscribe to a belief system that magnifies an object or a personified animal or deity as an item of worship value that attachment object as a source of strength, provision, or protection. This registers as a positive pleasurable experience and thus a reinforced behavior. As the individual develops a reciprocal relationship with the object, roles within the relationship are defined and self-concept is nurtured. An example of this is the personification of a deity expressed as "God, the Father". Identification with attributes related to the object, in this case "God" in a parental role, can modify the self-concept thereby allowing the individual to assess the threat and risk associated with the event through a broader lens that expands the boundary of individual ability, logic, and reason into a more transcendent realm of possibility.

RESILIENCE THEORY

Risk and resiliency theory effectively conceptualizes the process of assessing threat and risk and addresses the role of religion and spirituality in balancing assets and resources (i.e. having a relationship with an all-powerful deity) against threats posed by

chronic illness. Resilience is linked to life stress and people's unique coping capacity. It refers to the positive role of individual differences in people's response to stress and adversity, as well as hope and optimism in the face of adversity (Rutter, 1987). Resilience is the ability to maintain continuity of one's personal narrative and a coherent sense of self following traumatic events, i.e. normal development under difficult conditions (Greene & Conrad, 2002). Resilience has been used to describe individuals who adapt to extraordinary circumstances, achieving positive and unexpected outcomes in the face of adversity. Resilience is the presence of child, family, or extrafamilial environmental characteristics that allow for the chance of adaptive functioning in the face of severe risk. Protective factors are thought to decrease the negative impact of adversity and increase resilience.

Richardson (2002) presents resilience theory as three waves of resiliency inquiry. Resiliency inquiry emerged through phenomenological identification of characteristics of survivors living in high-risk situations. The first wave of resilient inquiry is resilient qualities or protective factors that include self-efficacy, easygoing temperament, and positive outlook as well as external elements within a family and a broader environment, such as having a warm and caring relationship with parents and having access to basic needs in a community.

The second wave is a resiliency process: the process of coping through a disruption and reintegration process. When people face adversity or life changes, they experience disruption, and through time and adaptation, they can choose to make a reintegration process. They can choose consciously or unconsciously to reintegrate resiliently,

reintegrate to the comfort zone (come back to the previous situation before facing adversity), or reintegrate with loss.

The third wave is innate resilience. Richardson explains that when people choose to reintegrate resiliently, they need a motivational force (energy) that drives them to make this reintegration. Richardson describes resilience theory as the motivational force within everyone that drives them to pursue wisdom, self-actualization, and altruism and to be in harmony with a spiritual source of strength. Resilience within this context, however, does not take into account socio-cultural factors such as poverty, socioeconomic status, exposure to trauma, interpersonal violence, and illicit drug use that have contributed to higher rates of HIV infection among African American women (Bauer, Rodriguez, & Perez-Stable, 2000; Hampton, Oliver, & Magarian, 2003; Wechsberg, Lam, Zule, & Bobashev, 2004; West, 2004; Wingood & DiClemente 1997; Wyatt et al. 2002; Prather et al. 2006). To utilize resilience theory as an explanatory concept for women's ability to return to their previous state following an adverse or traumatic event would assume that the previous state and/or conditions were favorable (Williamson, 2003). For many African American women, the difficulties listed above serve as contributory factors to current ills; realities not wished to be revisited. This incongruence can be explained using transformational learning theory.

TRANSFORMATIONAL LEARNING THEORY

Jack Mezirow (2000) inferred that significant learning involves meaning-making that leads to a transformation of personality or worldview. Courtenay, Merriam, and Reeves (1998) conducted a study of meaning-making in HIV positive adults and found

that perspectives and consequently, relationships and behaviors, changed following diagnosis. The integration of transformational learning theory is key to the discussion of coping among African American HIV positive women due to its relational context. Transformative learning is the process of effecting change in a frame of reference. In this process, an antecedent event triggers self-examination and previously held assumptions which are then shared and challenged, contributing to the construction of new and different roles within relationships and accompanying behaviors. The new perspective is then integrated into daily life essentially changing the present conditions. Transformational learning theory within the context of illness and coping has greater applicability than resilience theory. Richardson's afore-mentioned assertion that resilience theory is the motivational force within everyone that drives them to pursue wisdom, self-actualization, and altruism and to be in harmony with a spiritual source of strength, must also be viewed within the context of relational spirituality in order to be applied appropriately to this population.

Discussion

The selected theories are highlighted to conceptualize spirituality as it is expressed through the myriad definitions of religion and culture found in the relevant literature. Each theory presented asserts that individual perceptions of reality are guided by a search for meaning and connection and influenced by interaction with others. Forte (2004) argued that symbolic interaction can be used by social workers to understand culturally different interpretations of similar social experiences, and explore meanings such as those of the members of undervalued groups. In this frame, social work practice

interventions can benefit from the recognition of spirituality as a buffer mechanism in various cultures and populations. Struggles that clients may face during the process of searching for meaning and a connection to the sacred delineate key intervention points that can be overlooked without, at minimum, comprehension, and then appreciation, for the spiritual person and process. Studies have shown that patients may experience spiritual distress after being diagnosed with a serious and chronic illness (Holt, Lewellyn, & Rathweg, 2005; Pargament, McCarthy, Shah, Ano, Tarakeshwar, & Wachholtz, et al, 2004). For HIV positive women, disclosure of HIV status, fear of debilitating illness or death, and the possible loss of social supports and social networks are common stimulants for depression and anxiety (Murphy, Austin, & Greenwell, 2007; Serovich, McDowell, & Grafsky, 2008). They may feel that they are being punished by God or may have a loss of faith.

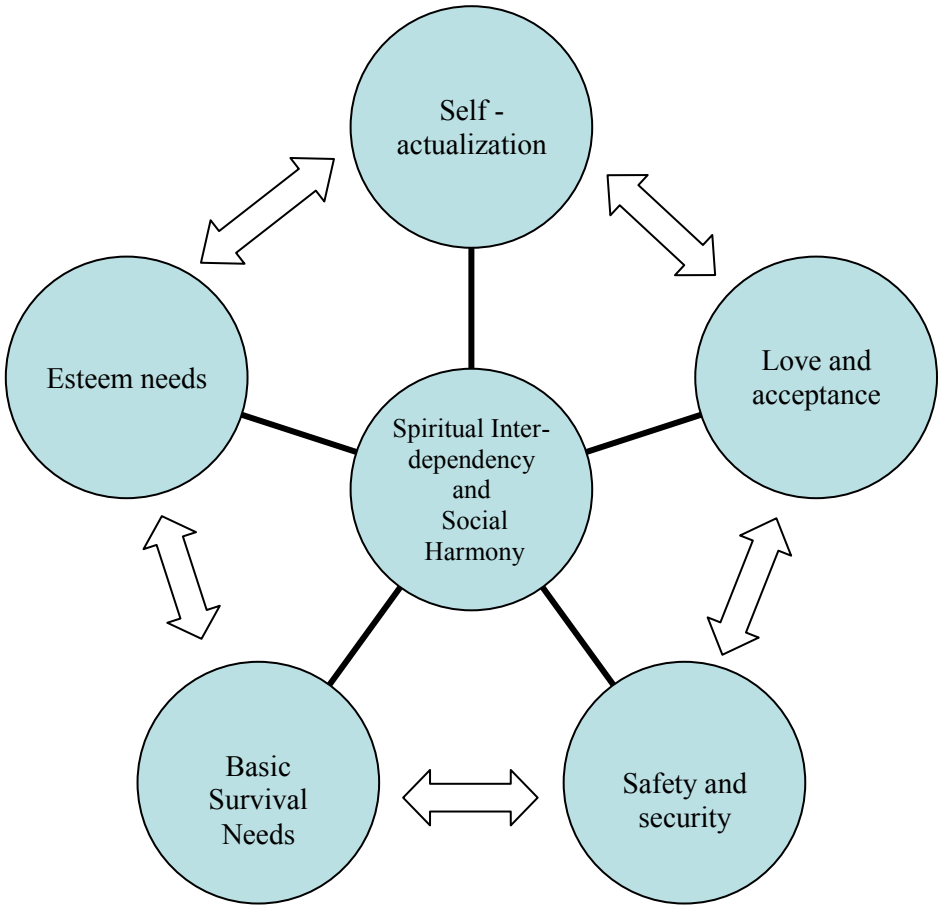
Church attendance, spiritual life, and connection are central constructs for African American women living with HIV. When viewed through the lens of the Health Belief Model and Lazarus and Folkman's transactional theory of stress, appraisal, and coping, spirituality buffers the psychosocial stressors that result from HIV infection. Considering the target population, maintenance of the spiritual dimension of the self is an imperative. Spirituality has been found to reduce levels of anxiety and fear in women recently diagnosed with illness, helping them to find meaning in the situation (Simon, Crowther, Higgerson, 2007). Accordingly, different dimensions of spirituality and religiosity are positively correlated with coping and adapting among HIV-infected individuals (Somlai & Heckman, 2000). Consequently, a loss of faith or disruption in spiritual connection

and guidance can be detrimental to psychological well-being and quality of life for the spiritual person.

Understanding spirituality in the context of the client system is crucial to the delivery of culturally competent practice. For African American women living with HIV, awareness of their preferred coping mechanisms, its function, and diverse origins can contribute greatly to increasing the availability of culturally relevant psychosocial interventions. In our attempts to understand what works and what does not work for this population, we cannot overlook the significant role that spirituality plays in each individual.

Figure 2.1: Adaptation of Maslow's Hierarchy of Needs

Figure 2.2: Cyclical Interdependent Function of Spirit



CHAPTER 3: IDENTIFYING SPIRITUAL MARKERS IN AFRICAN AMERICAN HIV POSITIVE WOMEN

A considerable range of socio-cultural factors such as socioeconomic status, substance abuse issues, exposure to trauma, misconceptions about HIV prevention messages and religious beliefs (Wingood and DiClemente 1997; Wyatt, Myers et al. 2002; Wechsberg, Lam et al. 2004; Prather, Fuller et al. 2006) have contributed to the exponential rise in HIV infection, and subsequently higher levels of psychological distress among African American women. For many HIV positive African American women, treatment of HIV infection and the subsequent psychological stress is complicated by lack of resources and competing life priorities. These women also face additional challenges such as fear of disclosure and lack of adequate social support. Stigma surrounding HIV and mental illness is highly prevalent in the African American community and many African American women are reluctant to seek formal mental health services. Although common seeking assistance from faith communities has presented a challenge for some African American women who are HIV-positive. Disparaging attitudes and discrimination are intensified toward women because it is assumed that most women with HIV are also members of other stigmatized groups, specifically, injecting drug users or sexual partners of IDUs, women of color, poor women, sexual partners of bisexual men, and women who previously led a lifestyle of sexual indiscretion (Jones, 2005). Fear and stigma surrounding HIV has left many African Americans who were once active in their faith communities isolated. Those who have remained in their community may not be comfortable with disclosure and consequently do not receive needed counseling and support. The complexity of

challenges faced by African American women who are HIV positive highlight the need to explore their preferred ways of coping. This article will present qualitative data that identifies, defines, and describes various uses of spirituality as a coping mechanism by African American women living with HIV.

Literature Review

Studies show that African American women tend to utilize informal coping resources when faced with dual mental and physical health challenges. Prayer, religious involvement such as church attendance, and social support are identified as active coping strategies among African American women. One study found that in comparison with Caucasian women, African American women were significantly more likely to report using prayer as a coping strategy and significantly less likely to seek help from mental health counselors (El-Khoury, Dutton, Goodman, Engel, Belamaric, & Murphy, 2004). Spirituality has been found to have a direct relationship with cognitive and social functioning and inversely related to HIV symptoms among African American women. In a sample of 448 HIV positive African American men and women, prayer was reported as a highly efficacious self-care strategy by over 50% of the respondents to manage symptoms of fatigue, depression and anxiety, and nausea (Coleman, 2006). Other studies have evidenced that among HIV positive African American women, high levels of spiritual well-being are positively correlated with the number of spiritual practices used, less depressive symptoms, and CD4 cell count (Dalmida, 2009; Scarinci, 2009). A 2004 study of urban, low-income HIV positive African American mothers suggests that social support, active coping, and avoidant coping responses mediate the relationship between

religious involvement and psychological distress and promotes involvement in religious institutions and practices (Prado, Feaster, Scwartz, Pratt, Smith, & Szapocnik, 2004).

Social relationships and affiliation have powerful effects on physical and mental health and well-being (Berkman, Glass, Brissette, & Seeman, 2000). Research suggests that socially isolated or socially marginalized individuals are less healthy psychologically and physically, and more likely to die prematurely from illnesses (House, Landis, & Umberson, 1988). People who have not disclosed their status to anyone other than health care professionals may prevent potentially negative social, personal and material consequences, but may also limit their own opportunities for social support, an important factor in coping and recovery from physical illness (Winstead, et al., 2002). Studies found in the literature identify both social and familial support (Sankar, Luborsky, Schuman, & Roberts, 2002; Edwards, 2006; Owen-Smith, DiClemente, & Wingood, 2007) and stigma (Sankar et al., 2002) as contributing determinants to medication adherence, a key factor in slowing HIV disease progression.

Social support buffers the impact of traumatic events on an individual (Declercq & Palmans, 2006). A study examining trauma history and posttraumatic stress symptoms in HIV-positive young adults, found 93% of the sample reported receiving an HIV diagnosis as a traumatic event (Radcliffe et al., 2007). Studies of other traumatized populations have found spirituality to be negatively correlated with trauma symptoms arguing that the potential buffering effects of spirituality as an experiential process may outweigh the severe, repetitive, and often chronic nature of abuse and victimization (Watlington & Murphy, 2006). Many survivors of abuse report that spirituality is a main

component of their identity, a source of strength and healing (Raphael, 1998; Farrell, 1996 as cited in Hassouneh-Phillips, 2003). In study of 151 women, 97% said spirituality was source of comfort or strength (Gillum, Sullivan, & Bybee, 2006). Though spirituality and religious participation are common coping strategies among African American women, formal mental health interventions are also necessary to address the magnitude of psychological stressors often experienced by women diagnosed with HIV.

Methods

This study performed secondary data analysis on a previous study. The purpose of the original study was to give voice to HIV positive African American women living in rural (southern state) (P.I. ---). The main research questions for this study were (1) how did women living in rural (southern state) discover they were infected with HIV?; and (2) what are the lived experiences of women living with HIV in rural (southern state)?

The study followed a modified version of the grounded theory framework and served as a needs assessment pilot study. Thirty-four African American women who live in (southern state) Public Health Region 3 were recruited for the study. The participants had to be HIV positive for at least one year and at least 25 years old. Participants were recruited from several health agencies that provide services to women who are HIV positive. Interviews were conducted over the span of 6-months and were recorded using an audio digital recorder. The study was approved by --- Institutional Review Board. Member checking was conducted in the original study to ensure the rigor of the analysis. Although member checking was not an option for the secondary analysis, the principal investigator of the original study served in a supervisory role to oversee the analysis and

use of the data. For the current study, a sample of fourteen interviews was analyzed. Whereas the original study used a grounded theory approach which allowed the researcher to create thematic codes in real time as data are collected, transcribed, and analyzed, the current study utilized content analysis to explore themes in the experiences of participants as it relates to the role of spirituality and social support and help-seeking behavior.

Content analysis is a research tool used to determine the presence of certain words or concepts within texts or sets of texts. Qualitative content analysis is defined as the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns. Researchers quantify and analyze the presence, meanings and relationships of such words and concepts, then make inferences about the messages within the texts, the writer(s), the audience, and even the culture and time of which these are a part. This study used directed content analysis to assess the experiences of HIV positive African American women. Directed content analysis is guided by a structured process that uses existing theory and prior research to begin to identify key concepts as initial coding categories (Hsieh & Shannon, 2005).

For this study, the researcher reviewed the interview transcripts for preliminary analysis. Transcripts containing direct references to faith, religion, spirituality, God, prayer, clergy, church and related terms were selected for analysis. Upon the initial review, passages containing relevant references were highlighted for identification in the second review. Highlighted passages were then analyzed for categorization. Categories were determined a priori using references from current and relevant literature.

Categorical areas identified in the literature related to spirituality and informal coping strategies in African American women included prayer and meditation, church attendance, Bible reading, formal groups, family/friends, support from pastor or clergy, having a relationship w/God, coming to terms with HIV/AIDS, helping others, and expressed satisfaction with one's current life situation. Statements that fell into either of these categories were then group together to interpret intended meaning and accompanying themes.

Operational definitions for each category are then determined using the theory. The goal of this research is to identify and categorize all instances of spiritual and social support, therefore coding began by reading the transcripts and highlighting all text that on first impression appeared to represent an expression or experience of spiritual or social support. Predetermined codes were used to code all highlighted passages. Any text that could not be categorized with the initial coding scheme was given a new code. To attempt to limit the subjectivity, reliability and validity, coding implicit terms involved the use of contextual translation rules. Interpretation commenced as essential themes emerged from the responses as to what was essential to the function of spirituality among African American women living with HIV.

Analysis of the qualitative data can help to identify the mechanisms by which spirituality and social support impact quality of life for HIV positive women and inform the design and development of interventions that provide necessary health and mental health services to this population. The analysis will employ deductive category application by utilizing previously formulated theoretically derived aspects of analysis,

bringing them in connection with the text. Categories will be methodologically assigned to passages of text. The step model for the analysis is outlined in Figure 3.1.

Figure 3.1: Step Model for Content Analysis

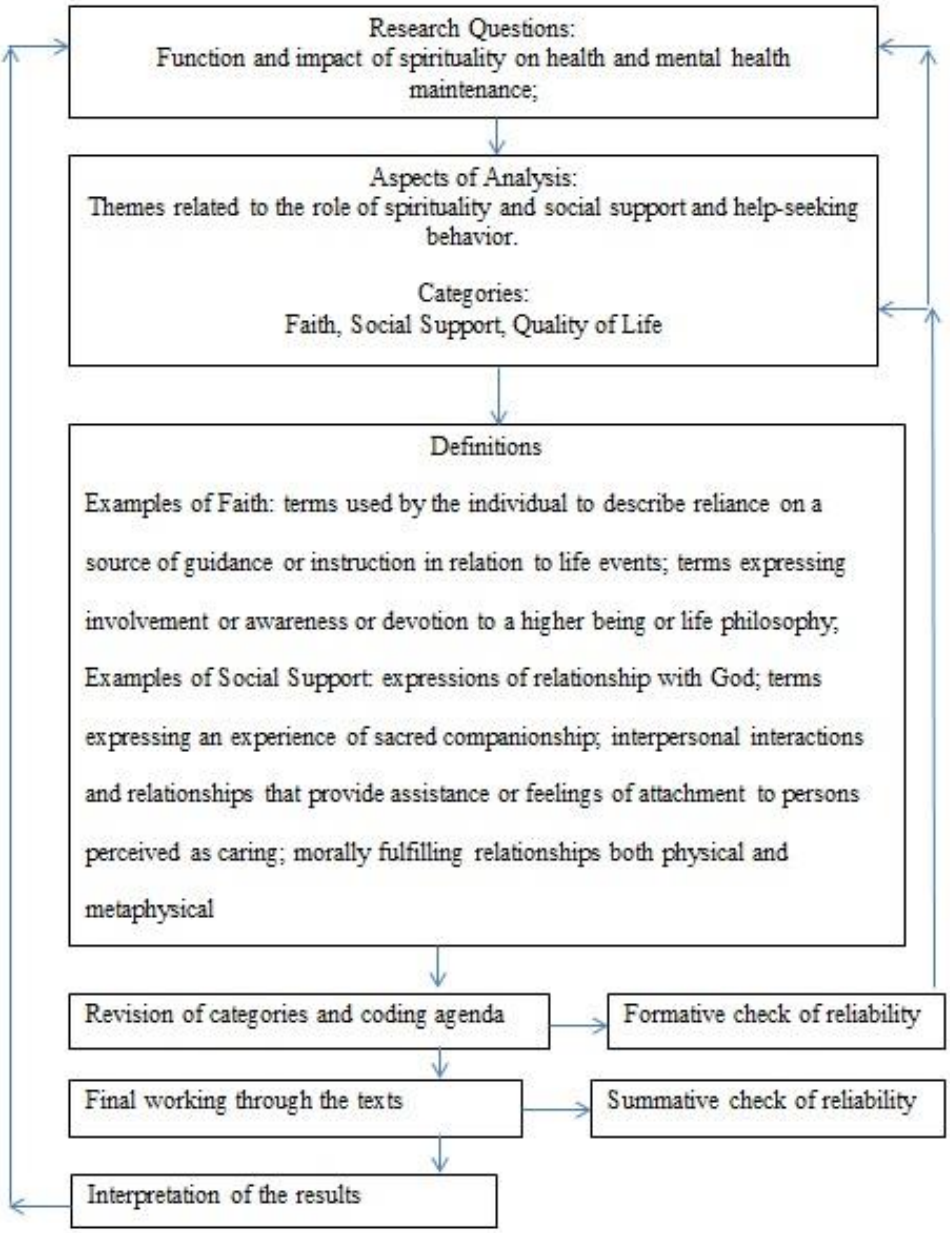


Table 3.1: Category Definitions and Coding Rules*

Themes	Category	Definitions	Examples	Coding Rules
Faith	C1: prayer/meditation C2: Church/group attendance C3: Bible Reading	used by the individual as a source of guidance or instruction in the midst of challenging life events, such as grief, loss, sickness, and hardship; Degree of involvement or state of awareness or devotion to a higher being or life philosophy;	Prayer, meditation, church attendance, artistic expression, involvement in twelve-step groups, meditation, or retreat centers	Can be any aspect of the definition. Other examples to be identified.
social support	C4: formal groups C5: family/friends C6: pastor/clergy C7: relationship w/God	expressions of relationship with God; experiencing sacred companionship in daily life; morally fulfilling relationship between oneself, other people, the universe, and the metaphysical	expressed in sayings such as "God is everywhere with me", and described God as "walking beside me"; formal or informal relationships based on spiritual/religious beliefs;	Can be any aspect of the definition. Other examples to be identified.
quality of life	C8: Coming to terms with HIV/AIDS C9: helping others C10: expressed satisfaction	an individual's perception of life conditions and personal satisfaction including, but not limited to, physical functioning, cognitive functioning, emotional status, and social role performance	concerned with practical issues in day to day activities affected by HIV/AIDS (med adherence, diet, physical activity; internal and external social consequences; attribution	Can be any aspect of the definition. Other examples to be identified.

*Category definitions, prototypical text passages, and rules for distinguishing different categories are formulated in respect to theory and material. They will be completed step by step and revised with the process of analysis.

Findings

The interviews were designed to answer the following questions: (1) how did women living in rural (southern state) discover they were infected with HIV?; and (2) what are the lived experiences of women living with HIV in rural (southern state)? Several themes were apparent throughout the interview data such as the experience of living with HIV, difficulty acquiring needed financial, housing, and support services, familial and relationship issues, concerns about disclosure, church involvement, battles with depression and post-traumatic stress disorder, and suggestions for improving services for HIV positive African American women. A key element that emerged spontaneously in many of the interviews was spiritual expressions of faith and reliance on "God".

This study sought to identify themes related to spirituality and social support for African American women living with HIV. Statements relating to spirituality and spiritual support were analyzed to determine how spirituality was used as a supportive construct. Three themes composed the core constructs of the women's spiritual experience while living with HIV. Though each interview was conducted individually, many of the women used terms and expressions that suggest a shared or similar vantage point regarding spiritual and religious belief. The core themes found within the interview data related to spirituality were faith, social support, and quality of life.

Faith is characterized as an integral process underlying the formation of beliefs, values, and meanings. Fowler (1997) defined faith as "the pattern of relatedness to self, others, and our world in light of our relatedness to ultimacy". The concept of ultimacy

refers to whatever a person understands as the ultimate or most profound basis of reality that gives orientation to her or his life. This can be viewed as dependency. Some examples of faith include reliance on a source of guidance or instruction in relation to life events or being devoted to a higher being or life philosophy. Examples of Social Support would include expressed relationship with God, interpersonal interactions and relationships that provide assistance or feelings of attachment, spiritual and social support from family and friends, as well as support from clergy, congregants, and identified morally fulfilling relationships with others. Quality of life describes an individual's perception of life conditions and personal satisfaction across a wide variety of domains, including, but not limited to, physical functioning, cognitive functioning, emotional status, and social role performance. Quality of life was also determined by meaning making and how participants perceived the severity of illness and levels of support received from their significant others.

Occurrences of each theme often overlapped in the analysis. For example, a participant would imply having a relationship with God, which is categorized as faith, and at the same time discuss attending church services, which is categorized as social support. Overlap was also found in the utilization of spiritual coping. For example, two participants spoke of substance abuse. One woman credited God for getting her off crack, while the other stated she would go to church to ask others to pray for her deliverance. These themes and other occurrences will be discussed below.

FAITH

Various manifestations of faith were illuminated in the participant interviews, including prayer, expressed relationship with God, and Bible reading. Of the 14 transcripts reviewed, 12 participants openly discussed faith as a coping mechanism in their individual interviews. These activities were used by the women as a source of guidance in the midst of challenging life events. The women expressed an awareness and devotion to a higher being many referred to as God. The Afrocentric interpretation of Maslow's hierarchy of needs suggests that within a spiritual context, the human's base level or primary need is knowledge or acceptance that one is connected to something other than or greater than the self. A loss of spiritual connection with self and cultural roots can cause real life crisis for many African American women. Conversely, a reconnection with cultural and historical spiritual roots can restore a proper inner balance. Faith in God as a spiritual foundation, or "root", was expressed by several participants. Faith is referred to as a "way out" of addiction for one participant.

> *"… As far as my addiction, when I would go to groups that was a trigger for me, because in the groups they would only, NA and AA groups, they would always talk about drugs, and alcohol, so uh, alcohol wasn't my drug of choice, but crack cocaine was. So listening to this all the time completely going through my mind over and over again was a trigger. So I had to find another way out. And my other way out was from my own roots. My um, stepfather was a minister. And I was pretty much raised up in the church, so I went back to church and uh, I met this guy and moved next door to this guy, a wonderful man, and we dated for about two years and we got married after a year. And he's a good man, he's a*

Christian man. And we both joined church and we got married and we both been singing in the choir for almost eight years together. So that's, going to church, my faith in God is what brought me through. My faith in God is what held me up when I found out about the information that I have HIV. My faith in God is what took me off crack."

The participants expressed a pervasive reliance on God for many things, spanning an array of events, hopes, and desires. Phrases used frequently by participants included *"I put everything in God's hands"; "leave it in the hands of the Lord"; "my Father got this in His hand"; "…it's up to God…how He wants to do";* and *"…just give it over to God. He'll take care of it."* This reliance seemed to eliminate fears and doubts of the unknown in terms of life expectancy and plans for the future. One participant said

"You got to be strong with this sickness! With any sickness you have to be strong. You be destroyin' your life by worryin' bout your sickness. I'm not gonna worry about it. Cause my father got this – in his hands …"

Another participant discussed her own mortality in this way:

"… I put everything in God's hands. That's the reason why I'm stronger every day. The way that I am… I leave everything in God's hands….because when he wants me to go, he will take me."

This sentiment was shared by another participant when discussing her journey:

"I put all my stuff with God, you know. Just give it over to God. He'll take care of it. And if it do turn to AIDS, I know how to cope with it. Because I had people talk

to me about that, so I don't have to worry bout that if it turn to AIDS. So its up to God, how He wants to do, how He take it away you know…. I was lost and I came back to a female preacher and she told me you can fight with it, you can live with it a long time. You can be eighty years old and still got it. You can be ninety years old and still got it. God, one day He gon' come home and take you and your time is gon' be up. So I'm not scared no more…"

Women in the study spoke not only of spiritual needs, but also physical and practical needs such as food, housing, medical care, and case management services being met by "God". Structural and systemic supports such as the availability of the food pantry and formal support groups were also attributed to the favor and grace of a loving God. One participant speaks about her transition into a new home:

"…I haven't worked since December 10th 2008 and the Lord have blessed me to maintain this household. Because when I first move in here girl nothing was in here. We didn't have anything. But a few clothes, like a couple comforters. We were sleeping on the floor, you know what I'm saying? …Just a little bitty food…things of that nature. And then I look at it now how the Lord have increased you know. So I just really just had to give it all to – you know, glorify his name, because he made it all possible…"

While God was credited as provider and protector, negative influences thoughts, and feelings were attributed to the works of "the enemy" or "satan".

"[God] was still watching over me, because the enemy tried to kill me so many times, so many times. I mean just physically take me out. That was his purpose."

"… I know the healing power of the Lord and I look to that as well. By his grace I know I'm healed. But then too I have to – I am realistic about how the devil works as well"

"You know, the devil can work with you in a lotta ways too. That was him. And I'm – I'm just thankful that the Lord stepped on in there – and moved him away."

Not only was God embodied as the evictor of the devil, God was also credited with removing depression:

"Cause only he can remove that depression – and all that evil stuff and things you wanna do to people. You know, just – you know cause this is depressing here – having HIV. It is a stressful thing too. So you get a lot a emotions. But I don't know. This thing is ah – prayin, go to church, and hear the Lord's words. And that – basically – I depend on him for everything…"

Faith in prayer was also cited by several participants. Most poignantly, one participant cited prayer in her decision to not keep a gun she had purchased to kill her abusive partner.

"So after so many beatings I bought a gun and I was gonna kill him the next time he jumped on me, but uh, I prayed about it and I sold it. I took it right back to the place where I bought it at and I sold it back to em for half price I bought it for,

and I bought me a ticket to Dallas and I went to uh Genesis Battered Women shelter."

SPIRITUAL SUPPORT AND FAMILY AS SPIRITUAL STRENGTH

Eight of the fourteen transcripts offered different types and levels of support. Social support can be found in formal groups, family, friends, and clergy, or activity such as attending church. Participants cited immediate family, spouse or significant other, formal support groups and even services at the Veteran's Administration hospital and community organizations as mechanisms of support. Whether formal or informal, participants discussed various levels of companionship and fulfilling relationship with others. An emerging theme for several of the women in the study was clergical support. Some participants relied on their pastors or minister for moral and social support particularly regarding issues of treatment and disclosure- *"before I told my son, I told my pastor"*. The magnitude of these relationships was discussed by several participants.

"…but it's my pastor, his wife, and one of the ladies, they're the only ones that know"

"the night after [the doctor] told me I was I was never going to tell anyone, my mind made up… I told my mom, a few minutes after I told my mom, my pastor called so I told him and my pastor being the person he is, he's more like a father figure…"

"my pastor was slowly trying to educate me… which was very helpful… and um, the case manager would say, well we got this class coming up or we got this class coming up. I didn't want to go to any of those classes. But with him being my POA [power of attorney], he took me to all my doctors' appointments…and signed me up for all these classes."

Another participant discussed church attendance in the midst of her drug use in an attempt to be "normal".

"… The whole time I just wanted to be normal. The whole time that I was on drugs I would still go to church. I would find somebody's church and I would sit in the back and sometimes I would say a poem and sometimes I would tell my story and sometimes I would just ask them to pray for me, to give me deliverance from this wicked drug, from the way that I was living, the prostitution, everything that goes with it. You know."

Amidst the proclamations of faith and expressions of belief and reliance on a higher power or God, several participants also voiced their concerns regarding the lack of formal and familial support:

"…they said there was no support services there-I mean, no support groups or nothing because people did not want anybody to know. And I was like, are you kidding me? I was like this is 2002, are you kidding me? They were like no, we don't-this is it. This is all you're gonna find. There's nothing else".

One participant discussed the difficulties she and her husband, who is also HIV positive, have supporting one another-

> *"So you make do with what you have and move on. Um, emotional [support], I don't and neither does he have a man to talk to, not even at the church what have you, to just freely expose that we have this. So, these are the issues, um, there's there's no support and because of no support my family or his family, its caused a wedge between he and I sometime. Because there are times when I need his emotional support and I can't get it"*

Many of the women interviewed had children, spouses, and parents that constructed their support networks. When asked about the needs of affected family members, one participant said this:

> *"… counseling um, emotional support cause, when a child… when a child is going through so many things. Trying to adjust, um, neighborhood, school, this is momma gonna live, um, why does this happen to my mommy? Why does daddy have it to? What can I do? Cause sometimes they don't know how to ask the questions and sometimes they act out. Because they don't know how to deal with this they're only children, its like a baby can't tell you come change me. He's gonna cry, um children and family, anyone around the family need support and counseling.*"

Women also discussed the lack of support and stigma in their faith and/or church community.

> *"I share at church, not about HIV… because they're not ready for it"*

"I know as for me and my pastor…when I came out and told everyone I was positive. No one in my church um, didn't accept me. But there was other pastors who called my pastor up and said either you kick me out of the church or they wouldn't want to fellowship with us anymore."

MEANING MAKING AND TRANSFORMATION

The least number of occurrences fell under the theme quality of life. Though most of the women on varying levels had come to terms with living with HIV/AIDS, only 3 documented their experience by giving examples in their interviews. Their individual perception of life conditions and personal satisfaction were generally hopeful and sometimes bordered on fatalistic. Because of transformed outlooks some experienced, participants also expressed a desire to help others facing similar issues.

"…after that I came to the conclusion that when we are born our destiny's already set for us, God has already made a plan, so it was meant to happen, it was just time, so I took it like that and said that I would find out more about the disease."

"… this is my purpose in life. And I realize my purpose, I didn't understand my purpose at first, um in the past I would've never done anything to do with HIV."

"… it pushed me to empower other people… so I started a ministry in my church, which is no longer in the church, we have become a 501C organization now…our objective is to help restore life and to help the people living with HIV and AIDS."

"And I'm one of those people, I … need to volunteer more, but I'm trying to juggle everything else. Ya know, I'm trying to be to get good at what… I'm trying to in my daily life, cause I could be good at that for I can be good for someone else. But I have to be good for me, before I can be good for someone else."

"…if you are diagnosed with the virus, your life has not changed. You still live a good healthy life. Of course, the first time you find out about it, of course, you going to be kind of stunned and scared, down, stressed, but as long as you have heart. Everything's going to be good. Everything's going to be really good. As long as you believe in God, everything's going to be real good. Put everything in God's hands."

In spite of the difficulty one may face living with HIV disease or AIDS, the spiritual and religious beliefs of the women interviewed present a backdrop of faith and resilience peppered with a hope and reassurance of reward. When the idea of taking one's own life was approached in one interview, this was the response:

"I know I wouldn't have no streets paved with gold, and wouldn't have no mansion, none of that. So I want every bit of that. The Lord saying his father's

house has many mansions – I want one! And I wanna walk down a street paved with gold too. So you kill yourself you know you're not goin' – he not callin' yo…- cause your life aint yours to take."

Limitations

Several limitations exist in this study. First, spiritual support was not the focus of the original research question. Therefore, the statements made by participants are merely ancillary, and not subject to additional probes that would have elicited more in depth responses. Also, data was not collected on the specific religious background or spiritual orientation of the participants. The themes here are generalized based on commonly used terms to identify subjects of a religious or spiritual nature, i.e., God, spirit, Bible, church, pastor, prayer, healing. The findings from this secondary analysis are only preliminary. While the findings will not be statistically generalizable, there is ample quantitative data highlighting spirituality as a resource for African American women.

Discussion

This study sought to identify spiritual and social supports in African American women living with HIV. A majority of the interview data considered for analysis made reference to God. The participants in the study interpreted life, health, shelter, provision, even medical services as gifts from God. Core elements of the interviews place church and spiritual life or connection to a higher power as central to perception of self, personal behaviors, and mortality. Identification of these core elements is essential in developing psychosocial interventions for African American women living with HIV.

Social networks such as congregations, online groups, community groups and councils often share similar core values or ideals. Within those core values lies a foundational belief of the origin of self and a sense of connection to some person or thing with which one coexists. These firmly held paradigms provide outlines for how an individual determines their own worth, power, eminence, purpose, and responsibility. In terms of health and health-related behaviors, these factors influence one's sense of control over or ability to impact a particular health- related situation. Therefore, autonomy and personal agency play important roles in decision-making regarding preventative health-related behaviors such as medication adherence, regularly scheduled doctor visits, healthy eating habits, and abstaining from recreational drug use. Personal autonomy involves the individual's ability to govern oneself and their degree of personal agency; more specifically, an individual's ability to make informed decisions about necessary preventative or reactive measures pertaining to their own health status. A person makes decisions within the realm of his or her own understanding and particular worldview and value system. The findings presented here offer a glimpse into the thought patterns and worldview by which many African American women with HIV live. The influence of the religious faith community on their life choices is immeasurable. The interaction within this social network impacts health, health literacy, and help-seeking behaviors. Its presence incites the need for continual and additional study of the impact of religion on behavioral factors related to physical and mental health. Junctures where these social networks have been fractured or severed for African American women living with HIV serves as a key focal point for psychosocial intervention.

When viewed through the lens of the Health Belief Model and Lazarus and Folkman's transactional theory of stress, appraisal, and coping, spirituality serves as a buffer that elicits a positive evaluation of the stressor- HIV infection. Reliance on faith-based ideals appears to assist many of the women as they cope with complex mental and physical effects of the disease. Immersion in a religious faith community influences many areas of everyday life for these women, as does its possible or permanent rejection. Religious beliefs can affect health related behaviors such as eating habits, physical activity, and sexual activity; as well as career orientation, communication, and social activity. It appears as a seamless thread running through daily life. The personal identity formed within those relationships seeks to fulfill the role outlined in an indoctrinated schema. For many of these women, it is the role of child, daughter, mother, or wife, as it was taught to them in their church, by their primary caregiver, clergy leader. Here, the connection to a larger system of principles and ideology serve as both a conduit and an outlet. It plays out in social interaction, prioritization of time and resources, as well as in decision-making and thought processes. The connection offers guidance or instruction in the midst of challenging life events, relying on learned faith principles in times of grief, loss, sickness, and hardship.

Implications of this research rest on the impetus of providing culturally relevant and appropriate psychosocial and mental health services. Some of the women in this study discussed multiple trauma revealing multi-faceted purposes for spiritualty and faith as a coping mechanism. Research findings support the importance of spiritual coping for women trauma survivors with co-occurring disorders and stress the value of increased

attention to spirituality in behavioral health services, especially in assessment and therapeutic relationships. Practitioners can help survivors draw on their spiritual resources to make decisions that promote their personal safety and well-being (Senter & Caldwell, 2002). "It is possible that by overlooking the spirituality of survivors, we social workers limit ourselves in helping them transcend abuse. Spirituality can be an enormous strength, coping mechanism, and source of comfort beyond what is provided in social work counseling. By expanding our understanding of spirituality and religion, we can help women empower themselves, heal, and find inner solutions for peace" (Bent-Goodley and Fowler, 2006, pg. 293).

CHAPTER 4: CRITICAL COMPONENTS: A REVIEW OF INTERVENTIONS DESIGNED FOR CO-MORBID HIV POSITIVE WOMEN

As HIV infection rates continue to rise for African American women, practitioners can expect to see a rise in anxiety and anxiety disorders within the population. The distress associated with a diagnosis of HIV infection can result in anxiety and depression about a range of issues, including treatment, mortality, stigma, and change in daily life. Research findings suggest that quality of life is significantly impacted by psychological distress and may also directly impact the course of HIV disease. More specifically, fatigue, pain, anxiety, and depression have all been identified as major mediators of quality of life. Studies have also found that anxiety experienced by persons living with HIV may be influenced by the stage of the disease, with learning one's HIV serostatus being one of the most anxiety-provoking times (G. R. Brown, Rundell, McManis, & Kendall, 1992; Flaskerud & Tabora, 1998; Lipsitz, Williams, Rabkin, & Remien, 1994; S. Perry, Jacobsberg, Card, & Ashman, 1993; S. W. Perry, Jacobsberg, Fishman, & Weiler, 1990; Salt, Miller, Perry, & Bor, 1989). Dually diagnosed women face significant emotional problems associated with HIV disease due to the disparaging attitudes and discrimination that are intensified toward HIV positive women including assumptions of substance abuse and sexual promiscuity (Jones, 2005). Given that psychological stress has been linked to HIV disease progression, and that studies have found elevated levels of anxiety in HIV positive women (Kaplan, Marks, & Mertens, 1997; Lambert, Keegan, & Petrak, 2005; Morrison, et al., 2002), the physical manifestations of psychological stress illustrated in anxiety disorder highlight key points

for intervention (Catz, Gore-Felton, & McClure, 2002).

Spirituality has been found to have a direct relationship with cognitive and social functioning among African American women. However, discussion of spiritual struggles and subsequent treatment approaches has been scarce in the empirical literature. A preliminary search of SAMHSA's National Registry of Evidence- Based Programs and Practices (211) found that of 219 interventions listed- 7 addressed HIV prevention and/or mental health and substance for HIV positive persons, 6 addressed persons living with HIV and/or women specifically, and 1 (substance abuse focus) addressed spirituality specifically. Few outcome studies have been conducted to address stress and anxiety in African American women living with HIV. Even fewer have incorporated a spirit-level component to address the unique needs of this population. The purpose of this article is to review relevant psychosocial interventions and describe their components and effectiveness. While some interventions may not overtly designate spiritual coping as an outcome, components embedded within the interventions can be identified to address spirituality and coping for co-morbid African American women.

Literature Review

Research has identified the benefits of religiosity and spirituality as they are functionally related to health, however, the measurement of spiritual outcomes and their effect on health and health behaviors leave much to be desired. Hill and Pargament (2003) recommend the development of new measures of religious or spiritual outcomes such as faithfulness, peace, forgiveness, gratitude or ''closeness to God''. The measurement of these concepts can differentiate between spiritual outcomes and the

function of spirituality. A qualitative study conducted by Lewis, Hankin, Reynolds, and Ogedegbe (2007) found that the way spirituality affected health for participants was through a process of honoring God, others, and oneself, an embodiment of faithfulness, peace, forgiveness, and gratitude. This process of honoring God, others, and self was described in four phases: believing in God or a higher power, establishing faith in God or a higher power, developing a relationship and connection with God, and living a "spiritual life". These spiritual outcomes were found to be motivating catalysts for meditation, prayer, physical activity, and nutritious eating. Using these examples inferences can be made toward the relationship between spiritual outcomes and the promotion of healthy active coping behaviors.

Interventions to lessen psychological distress in HIV positive African American women have focused on increasing social support, promoting active coping, and decreasing avoidant coping behaviors such as substance use (Kaslow, et al., 1998; Kaslow, et al., 2002; Murry, et al., 2008; Robbins, et al., 2003; Siegle, Karus, Raveis, & Hagen, 1998; Thompson, et al., 2000). Numerous trials have been conducted to study the efficacy of spiritual interventions to reduce smoking, and substance use, and also to promote cancer screening, and prevent HIV transmission in African American populations. Various components of spiritual health such as meaning and purpose in life; self-awareness; and connectedness with self, others, and a larger reality have been addressed using imagery, meditation, and group support activities. Other common interventions include prayer, scripture, presence, listening, and referral (Emblen, Halstead,) Discoveries of endocrine pathways between cancer and religion/spirituality

have led to studies of the effects of Eastern interventions such as meditation, mindfulness, and yoga on cancer patients (Koenig, King, & Carson, 2012). Western interventions have focused more on church-based or faith-based interventions involving group support to meet psycho-social-spiritual-educational needs of persons with chronic illness. Both Eastern and Western interventions have also been utilized for illness prevention efforts (Koenig, King, & Carson, 2012).

A series of intervention studies have demonstrated positive outcomes, including reduced psychological distress and improved immunological functioning (Evans, Leserman, Perkins, & Stern, 1997; Molassiotis, et al., 2002; Vassend, Eskild, & Halvorsen, 1997). Other studies have been aimed at helping HIV positive persons cope during particular crisis points over the course of illness (Kelly & St. Lawrence, 1988; Poindexter, 1997). These interventions used various cognitive-behavioral techniques to teach participants to relax, alter cognitive appraisals, use new coping strategies, and access social support resources. Research supports the need for comprehensive health care services that incorporate a holistic approach to addressing the many physical, psychological, and social issues faced by HIV positive women ((Ickovics, et al., 2001; Mast, et al., 2004; McDonnell, Gielen, Wu, O'Campo, & Faden, 2000; Vassend, et al., 1997).

LITERATURE SEARCH METHOD AND CRITERIA FOR INCLUSION

This section will provide an overview of the current state of intervention research as it relates to the development and evaluation of spirit-level interventions targeting anxiety and stress in African American women living with HIV. Database searches of

PsycINFO, Academic Search Complete, Alt HealthWatch, ERIC, Health Source: Consumer Edition, Health Source: Nursing/Academic Edition, MEDLINE, PsycARTICLES, PsycCRITIQUES, Psychology and Behavioral Sciences Collection, Religion and Philosophy Collection and Google Scholar were conducted to identify published articles in peer-reviewed journals that evaluated interventions for co-morbid women living with HIV. Combinations of the following search terms were used to identify relevant articles: Intervention, spiritual intervention, spiritually based, women, female, HIV, HIV positive, HIV positive women, HIV seropositive, HIV/AIDS, spirit*, spirituality, relig*, religion, religiosity, and faith. Auxiliary searches included the terms Black and African American. A search of references cited in relevant studies was conducted to identify additional articles. English language articles published in peer-reviewed journals were screened for inclusion. Studies were included if they met all of the following criteria: (a) the intervention's primary target population was women, (b) the study's sample was composed of only persons living with HIV, (c) the intervention addressed spirituality, spiritual coping, and/or stress and coping, and (d) the intervention did not focus exclusively on modifying other health behaviors (eg, sexual risk reduction, improvement in medication adherence). Intervention studies with a spiritual component but included men in the sample were also reviewed for context. For this review, studies that were not conducted with United States samples were excluded. Due to this review's focus on psychosocial interventions and their applicability and replicability for social and community workers, studies containing only biomedical outcome measures such as hormone levels and disease progression markers (i.e. viral load and CD4 count), were

also excluded. The selected intervention studies are categorized by spirit-level group interventions, and psychosocial interventions. A variety of methods are represented in the psychosocial interventions including individual therapeutic techniques, community collaboration models, and stress management. Spirit-level interventions either listed spiritual coping as a dependent variable or outcome, explicitly included spiritual behavioral activities (such as mantram, Tai Chi, or spiritual reflection) in the intervention content, and/or used tools measuring spiritual well-being for assessment. A distinction was made here between studies that introduce spiritual concepts and studies that elicited spiritual information from participants during the course of the intervention. Ecological studies focused on system or family level intervention. Health promotion studies focused on information dissemination and acquisition. Studies which included specific stress management techniques were categorized as stress management and may have also overlapped categories with spiritual interventions. Table 4.1 lists the interventions that met the criteria: targeting HIV positive women, addressed stress and coping specifically, and no exclusive focus on modifying other health behaviors. Table 4.2 lists interventions targeting HIV positive men and women and focused specifically on spirituality and spiritual intervention. Components of these articles can be useful when developing spiritual interventions for African American women.

Table 4.1: Multi-Component Psychosocial Interventions for HIV Positive Women

Title	Outcome Measures	Research Design	Assessment Tools	Intervention
Health promotion for women with human immunodeficiency virus or acquired immunodeficiency syndrome Abel et al (2006)	Barriers Resources Self-efficacy	pretest/posttest one-group design	The Center for Epidemiologic Studies Depression Scale The Stigma scale Self-Rated Abilities for Health Practices The Health Promoting Lifestyle Profile II	verbal explanation interactive exercises sharing health promotion experiences personal goal-setting health promotion skills practice
MOMS: formative evaluation and subsequent intervention for mothers living with HIV Davies (2009)	parenting skills maternal physical health status mental health status	randomized controlled behavioral trial	None	educational activities problem solving group discussion self-reflection social support building
Taking Action in Communities: Women Living With HIV/AIDS Lead the Way DeMarco & Johnsen (2003)	Peer advocacy Voice	action research community-based collaboration	None	Information sharing Community meetings one-day retreat
The SMART/EST (Stress Management And Relaxation Training/Expressive-Supportive Therapy) Women's Project Ironson, et al (2005)	Self-efficacy Depressed affect anxiety Medication adherence	Intervention/comparison group	The Self-Efficacy Inventory The Beck Depression Inventory Adherence to Medication Scale	didactic components rational thought replacement coping skills training assertiveness training anger management identification of social supports
A positive affect intervention for people experiencing health-related stress: Development and non-randomized Pilot Test Moskowitz, et al (2011)	positive affect negative affect Mindfulness	Pre/post comparison group	Differential Emotions Scale Five Factor Mindfulness Scale	Skill 1: Noticing positive events Skill 2: Capitalizing Skill 3: Gratitude. Skill 4: Mindfulness Skill 5: Positive reappraisal Skill 6: Personal strengths Skill 7: Create attainable goals Skill 8: Acts of kindness
Structural Ecosystems Therapy for HIV+ African-American Women: Effects on Psychological Distress, Family Hassles, and Family Support Szpocznik, et al (2004)	Psychological distress Family hassles Family Support	intent-to-treat, mixed design three conditions and five assessment points	The Global Severity Index from the Brief Symptom Inventory The Hassles Scale Social Support Questionnaire (SSQ) Short Form	individual therapy

Table 4.2: Multi-Component Spiritual Interventions for HIV Positive Men and Women

Title	Outcome Measures	Research Design	Assessment Tools	Spiritual Intervention
Effects of Spiritual Mantram Repetition on HIV Outcomes: A Randomized Controlled Trial Bormann, et al (2006)	Intrusive thoughts Stress Anxiety Anger Depression Quality of life Spiritual well being	Randomized Clinical Trial 2-group by 4-time repeated measures design	Mini-Mental Status Exam Impact of Events Scale-Revised intrusion subscale Perceived Stress Scale Spielberger Trait- Anxiety Inventory Spielberger Trait- Anger Inventory-Short Form Center for Epidemiological Study-Depression Scale Quality of Life Enjoyment and Satisfaction Questionnaire Functional Assessment of Chronic Illness Therapy Spiritual Well-being–Expanded	The Mantram Handbook (Easwaran 2001; Oman and Driskill, 2003) weekly reading course manual with exercises list of recommended mantrams
A randomized clinical trial of alternative stress management intervention in persons with HIV infection McCain, et al (2008)	Psychological distress Coping strategies Quality of life	Randomized Clinical Trial	Dealing With Illness Scale Revised Social Provisions Scale Impact of Event Scale Functional Assessment of HIV Infection (Version 4) scale Spiritual Well-Being Scale	Relaxation techniques Mental relaxation techniques Tai chi Journaling Guided imagery Meditation
Lighting the Way: A Spiritual Journey to Wholeness Pargament et al (2005)	Spiritual struggles Spiritual resources	Pilot study	None	Drawing Reading spiritual poetry Prayer/candle ritual Biblical imagery Guided imagery Relaxation exercises journaling
Development and implementation of a spiritual coping group intervention for adults living with HIV/AIDS: a pilot study Tarakeshwar, et al (2005)	Self-rated religiosity Spiritual coping Depressed mood	Randomized controlled Pretest/Posttest design	The Brief Multidimensional Measurement of Religiousness/Spirituality The Center for Epidemiological Studies Depression Scale Beck Anxiety Inventory	Journaling Drawing Worksheets Essay Poem on surrender and forgiveness Serenity prayer Private reflection

Fifteen articles were found using the search terms. Of those, only 3 intervention studies targeted HIV positive African American women specifically. Of those three, only one study had an exclusive focus on spirituality. Five studies specifically addressed spirituality and spiritual issues with HIV positive men and women. Of those five, women represented less than 50% of participants in 4 of the samples. Three studies presented behavioral techniques to promote spiritual coping. In each of those studies, both women and African Americans were less than 50% of the sample.

Articles selected for review were multi-component psychosocial interventions for HIV positive women and multi-component spiritual interventions for women and men. The content of the intervention articles present a plethora of consistent yet varied issues of health and wellness in HIV positive women including lifestyle adjustment, intimacy and sexuality (Abel et al, 2006; Davies, 2009; DeMarco & Johnsen, 2003), stress management (Davies, 2009; Abel et al, 2006; Szpocznik, et al, 2004), nutrition and exercise (Abel et al, 2006; Davies, 2009), medication adherence and complimentary therapies (Davies, 2009; DeMarco & Johnsen, 2003), and communicating health needs with family, friends, and health care providers (Szpocznik, et al, 2004; DeMarco & Johnsen, 2003). The duration of each intervention ranges from 3 to 8 weekly sessions. Sessions range from 90-120 minutes in length.

Group level interventions assist HIV-positive women in adapting more positive coping skills, such as expressing feelings of anxiety and fear. Feminist research suggests that women with HIV/AIDS may use silence as a way to cope when they feel disempowered ((DeMarco, Miller, Patsdaughter, Chisholm, & Grindel, 1998). For these

women, silence and a lack of self-advocacy could lead to a poor quality of life or early death from the illness. Research suggests that socially isolated or socially marginalized individuals are less healthy psychologically and physically, and more likely to die prematurely from illnesses (House, Landis, & Umberson, 1988). Similarly, studies found in the literature identify both social and familial support (Sankar, Luborsky, Schuman, & Roberts, 2002; Edwards, 2006; Owen-Smith, DiClemente, & Wingood, 2007) and stigma (Sankar et al., 2002) as contributing determinants to medication adherence, a key factor in slowing HIV disease progression. There is also empirical and clinical evidence that social support buffers the impact of traumatic events on an individual (Declercq & Palmans, 2006). Support groups and interventions that include spiritual components can be beneficial to the psychological well-being of African American women living with HIV.

Spirit-level interventions for psychosocial stressors

The Lighting the Way intervention was the only study to meet the initial criteria for review. Born out of a review of the literature on HIV, spiritually based interventions, and interviews with low-income African American women with HIV, Pargament and colleagues (2004) tailored the 8-session group intervention for urban Black women diagnosed with HIV. The intervention addresses existential issues commonly faced by women living with HIV such as healing; body and spirit; control and surrender; letting go of anger; shame and guilt; intimacy and isolation; and hopes and dreams (Pargament, et al, 2004). The intervention also addresses spiritual coping resources such as meditation prayer, and spiritual support, as well as spiritual struggles; i.e., anger at God, stigma, and

feeling punished by God). Initial empirical support for the program can be found in Tarakeshwar, Pearce, and Sikkema's 2005 pilot study of a spiritual coping group intervention. Currently there is no available literature on the effectiveness of the Lighting the Way intervention.

Tarakeshwar et al (2005) spiritual group intervention targeted both HIV positive women and men to explore the feasibility of implementing a spiritually-focused intervention using a group format. The intervention used gender-based groups (heterosexual men/gay men/women). Women represented 38.4% of participants in the study, preferred slightly larger groups ranging from 8-10, and suggested adding more content on self-esteem. Participants also suggested the intervention be increased from 8 weekly sessions to a minimum of 15 weeks to develop group cohesion and discuss other issues such as relationships and housing. In concert with the Lighting the Way intervention, the spiritual coping group also included a variety of activities to promote spiritual reflection including journaling, drawing, worksheets, poetry, the serenity prayer, and private reflection. Additionally, the spiritual coping group presented four different styles of spiritual coping (self-directed, deferring, pleading, and collaborative) as conceptualized by Kenneth Pargament (1988) and their effects on life domains.

Bormann and colleagues (2006) studied the efficacy of mantram repetition, a psycho-spiritual intervention on psychological distress, quality of life, and existential spiritual well-being in HIV-infected adults. A mantram is a word or phrase with spiritual associations repeated silently throughout the day. The outcome suggested that the mantram group had more reduced anger and increased spiritual faith and spiritual

connectedness than the control group. However, disproportionate attrition rates were found in Bormann et al's study of mantram repetition, a mixed gender/mixed race group intervention. A disproportionate number of participants who dropped out of the study were non-white (66.7%), while only 43% of all participants in the study were non-white (Bormann, Gifford et al, 2006). Bormann et al repeated the study in 2009 hypothesizing that mantram repetition would enhance the effects of faith on cortisol, also known as the "stress hormone". Again, non-white participants (48%) dropped out of the study at a disproportionately higher rate (68% nonwhite versus 32% white). Additional inquiry is needed to determine whether participants discontinued the study in response to the inclusion of alternative and/or unknown spiritual practices.

Possibly the least effective of the spiritual interventions presented is McCain et al's (2008) alternative stress management intervention. The randomized clinical trial used three different 10-week stress management approaches to test effects on HIV positive men and women. Each approach, cognitive behavioral relaxation training (RLXN), focused tai chi training (TCHI), and spiritual growth groups (SPRT). Following the intervention the researchers found minimal change in emotion focused coping and psychosocial functioning, however improved immune function was noted among participants.

Taking Action in Communities (DeMarco & Johnsen, 2003), though not classified as a spiritual intervention, it discussed spirituality in women with living with HIV. The "What's in it for us?" series was a community based collaboration developed to provide inner-city women living with HIV/AIDS with peer support, education, and advocacy.

The series was comprised of five programs during 1997–1998 and covered topics such as therapy options; self-care and wellness; sexuality; and politics. Topics also included nutrition, symptom management, and the benefits of spirituality in maintaining a sense of well-being. A similar process was identified in the "Put Health into Living" project, a health promotion intervention designed to improve self-efficacy and increase health promoting behaviors in HIV positive women (Abel et al, 2006).

SYSTEMS/ECOLOGICAL INTERVENTIONS

Structural Ecosystems Therapy (SET) (Mitrani, Szapocznik, & Robinson-Batista, 2000; Szapocznik et al., 2004), is an ecological extension of Brief Strategic Family Therapy (BSFT; Szapocznik & Kurtines, 1989) developed to address the family and contextual factors of HIV+ African-American women. SET builds on Boyd-Franklin's (1995) multisystemic model developed though practice with African American and other minority families. In particular, the model stresses the importance of the family's inner resources to confront the myriad emotional and functional challenges of families affected by HIV/AIDS and improving families' interactions with health and other service providers. The intervention was designed to improve family functioning and strengthen the connections between the family and external resources to improve psychosocial adaptation to HIV/AIDS and reduce psychological distress.

Findings from the study applying SET to African American women with HIV indicated that women assigned to the SET condition had significant decreases in psychological distress during and after treatment than did those women in the control group. This study provided evidence for the efficacy of SET in reducing distress and

family-related hassles in HIV-seropositive African American women. A secondary data analysis of the original SET study HIV (Szapocznik et al., 2004) was conducted to examine the effect of SET on HIV medication adherence. Results of the secondary analysis demonstrated that SET significantly improved HIV medication adherence in African American women who are HIV+ compared to women assigned to a person-centered counseling condition. The results suggest that an ecosystemic approach to medication adherence may benefit low-income urban minority women, and offers support for ecological and family-based approaches for persons with HIV (Feaster, et al, 2010).

The Making Our Mothers Stronger (MOMS) Project was a randomized controlled behavioral trial completed to compare a stress-reduction and social support intervention (Healthy MOMS) to a parenting skills intervention (Parenting Skills for MOMS) for mothers living with HIV (Davies, Horton, Williams, Martin & Stewart, 2009). Outcomes to be studied included maternal mental and physical health, parenting behaviors, and children's behavior. Focus groups and semi-structured interviews were conducted to ensure that these interventions were tailored to the needs of HIV+ mothers. The formative studies highlighted the need for the interventions to include appropriate approaches to group discussion and problem solving; address the stressors of being both a parent and a woman living with HIV; and enhance social support. Topics included in the six weekly group sessions were coping with stress and anxiety; enhancing nutrition, exercise, and sexual health; improving medical adherence; improving communication with health care providers; and communicating health needs to family, friends, and co-workers. This project did not target African American women specifically, although 10

of the 12 focus group participants were African American. Formative evaluation was used in the development of Tarakeshwar's spiritual coping intervention. The pilot intervention held 8 sessions based on data collected during the formative evaluation process. Interviews were conducted with 10 men and 10 women to understand stressors related to HIV and how spirituality influenced their coping process. Multiple phases of development were also used in Abel's health promotion intervention to make changes to the intervention based on information from a focus group, a literature review, and an evaluation by an expert panel and community workers.

Challenges to Spiritual Assessment, Measurement, and Intervention

To date, none of the interventions discussed have been replicated and are therefore not generalizable nor can they be considered evidence-based. The current push towards evidence-based interventions necessitates the availability of accessible measures for practitioners that seek to conduct spiritual assessment and offer appropriate intervention. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recommends that a spiritual assessment be conducted to determine the client's denomination as well as important spiritual beliefs and practices (Hodge, 2006; JCAHO, 2008). Though much research has been conducted on religion and spirituality, there is no comprehensive measurement of religion or spirituality available in the medical, psychological, or sociological literature (Hall, Meador, & Koenig, 2008).

There have been many challenges involved in measuring global assessments of religiousness. Narrowing the focus of these measures has proven useful for some in identifying the various positive and negative associations between religiousness and

health. Current trends include concepts and measures of religiosity that are functionally related to health. One challenge is that most of these measures rely on self-report, highlighting the need for more objective alternatives to assessing religious practice. Other criticisms of measurement include the lack of sensitivity to context in measurement and subsequently, data collection and research methods. Much of the research focusing on religion and spirituality boasts samples of predominately white, middle-class and Christian, mainly Protestant faith. Contextual measures accommodating the religious practice of different races, cultures and religions will serve to expand the utility of assessment tools that are currently available. Table 4.3 displays various constructs identified in the conceptual and theoretical frameworks of the interventions presented here and the assessment tools used to measure those constructs. Though the listing is not exhaustive, researchers and practitioners may find the tools helpful in development and implementation spirit-level and psychosocial interventions.

Table 4.3: Assessment Tools

Adherence to Medication Scale (AMS; Chesney et al., 2000)
Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, Steer, 1988)
Beck Depression Inventory (BDI; Beck, et al, 1988)
Brief Multidimensional Measurement of Religiousness/Spirituality (BMMRS; Fetzer Institute, 1999)
Center for Epidemiologic Studies Depression-Scale (CES-D; Radcliff, 1977; Radcliff & Locke, 1986)
Dealing With Illness Scale (DIS; McCain & Gramling, 1992)
Differential Emotions Scale (DES) modified by Fredrickson et al. (2003)
Five Factor Mindfulness Scale (FFMQ; Baer et al., 2006)
Functional Assessment of Chronic Illness Therapy Spiritual Well-being–Expanded (FACITSpEx version 4; Brady et al., 1999; Mytko and Knight, 1999; Peterman et al., 2002)
Functional Assessment of HIV Infection (Version 4) scale (FAHI; Cella et al., 1996; Peterman et al., 1997)
Global Severity Index from the Brief Symptom Inventory (Derogatis, 1993)
Hassles Scale (DeLongis et al., 1988)
Health Promoting Lifestyle Profile II (Walker & Hill-Polrecky, 1996; Walker, Sechrist, & Pender, 1995)
Impact of Event Scale (IES; Horowitz et al., 1979)
Impact of Events Scale-Revised intrusion subscale (Horowitz et al., 1979)
Mini-Mental Status Exam (Cockrell and Folstein, 1988)
Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LESQ; Endicott et al., 1993)
Revised Social Provisions Scale (SPS; Cutrona & Russell, 1987).
Self-Efficacy Inventory
Self-Rated Abilities for Health Practices (Becker, Stuifbergen, Oh, & Hall, 1993).
Social Support Questionnaire (SSQ) Short Form (Sarason, Sarason, Shearin, & Pierce, 1987)
Spielberger Trait- Anger Inventory-Short Form (Spielberger et al., 1983)
Spielberger Trait- Anxiety Inventory (Spielberger 1972)
Stigma Scale (Sowell, Cohen, Demi, & Moneyham, 1992)

Discussion of Critical Intervention Components

Given the limitations found in the current research, there are significant implications for additional social work research and practice with co-morbid HIV positive African American women. Quality of life in women living with HIV has been severely understudied (Cowdery & Pesa, 2002). Frequent assessments should include information about the severity or intensity of anxiety symptoms and the degree to which these symptoms disrupt a person's daily functioning. Studies measuring anxiety alone are also scarce in the literature. Anxiety is often accompanied by panic disorder, posttraumatic stress disorder, depression, or substance abuse and is presented as such in literature and research (Adewuya et al., 2008; Brown, et al., 1999; Krefetz, et al., 2004; Savard, 1998). Accordingly, many studies have measured anxiety concurrently with depression. Fear and anxiety in HIV positive women may be minimized or ignored as a common response to HIV/AIDS. Consequently, anxiety is frequently unrecognized and underreported, indicating a need for ongoing assessment. It is important for providers to recognize that levels of fear and anxiety change over time, especially at various crisis points that occur during the course of HIV disease (Flaskerud & Miller, 1999).

Studies show that self-care is another key component to improved quality of life (DeMarco, et al., 1998; Inouye, et al., 2001). Dissemination of an intervention that teaches relaxation and how to confront irrational fears and thoughts will equip HIV positive anxiety sufferers with the skills needed to reduce anxiety on their own. Analyses of previous interventions have shown that significant intervention effects on

anxiety (and depression) were observed at immediate post-intervention assessment; however, there is little evidence for longer term effectiveness (Dancy, Marcantonio, & Norr, 2000; Sikkema, et al., 2006). Future studies should include follow-up or booster sessions in addition to post-intervention assessment to determine long term effectiveness. Persons with intense fear and anxiety may require a full range of supportive psychological interventions, including crisis counseling and medication. The introduction of an intervention designed to reduce anxiety will help practitioners better address the individual psychosocial needs of their HIV positive clients. In light of the previously presented research, it can be assumed that support groups and interventions that include spiritual components can be beneficial to the psychological well-being of African American women living with HIV and considerable effort is needed to make these therapeutic opportunities available.

The interventions presented in this article address either spirituality or stress and coping in HIV positive men and women. Whereas psychosocial interventions had better outcomes for reducing stress and anxiety in HIV positive women, some spirit-level interventions may offer promise to African American women who are HIV positive. Group process and group cohesion is a critical component for HIV positive women. An extended number of group sessions for time limited groups is also cited by women who participated in the psychosocial group interventions. Slightly larger groups were also preferred to smaller groups. Another key component within a group setting is the inclusion of discussion on relationships issues, esteem issues, and sexuality issues.

Spirit-level groups could benefit from more opportunity to delve deeper into how one's spiritual beliefs influenced various life domains. An additional element would be the inclusion of more exercises that called for spiritual reflection. Although spirituality and religious participation are common coping strategies among African American women (Arrindell, 2003; Dalmida, 2006; Watlington & Murphy, 2006), formal mental health interventions are necessary to address the magnitude of psychological stressors often experienced by women diagnosed with HIV. Increased availability of interventions designed to focus on the strengths found within spirituality and religion will help practitioners to better address the individual psychosocial needs of their HIV positive clients.

CHAPTER 5: CONCLUSION

The purpose of this dissertation was to elucidate African American women's use of spirituality as a coping mechanism. Three scholarly papers were presented to describe different aspects of this phenomenon. The final chapter of the dissertation will summarize each article, its contribution to the literature, its corresponding limitations, and the implications of each study in future research.

The first article, Conceptual and Theoretical Frameworks for Integrating Spirituality into Practice Interventions for HIV Positive Women, offers a conceptual framework incorporating the health belief model and a discussion of Lazarus & Folkman's stress and coping model for integrating spirituality into social work practice interventions for HIV positive women. Definitions of religion and spirituality are presented along with a discussion on the intersection of spirituality and culture. Several theoretical concepts were proposed to demonstrate the relationships between social interaction, belief, and coping within the context of illness. Presented under the arc of social cognitive theory were Attachment theory, Resiliency theory, and Transformational Learning theory. Each theory highlighted individual perceptions of reality as guided by a search for meaning and connection and influenced by interaction with others. The article also proposed an alternative illustration of Maslow's hierarchy of needs using an Africentric perspective to incorporate spirituality as a basic human need. Building on Och's (1997) model of relational spirituality, a diagram to depict the cyclical interdependent function of basic needs and the introduction of spirit in human

development was presented. This article provides a theoretical and conceptual framework for understanding spirituality within the context of the client system.

The second article, Identifying spiritual supports in HIV positive African American women, presented qualitative data that identifies, defines, and describes various uses of spirituality as a coping mechanism. This study utilized content analysis on secondary data to explore themes related to the role of spirituality and social support and help-seeking behavior. The impact of spirituality on quality of life and perceptions of illness were discussed to inform the design and development of interventions that provide necessary health and mental health services to the population. Though the population discussed is HIV positive women, a particular focus is on African American women as a sub-group. Much of the current literature on African Americans and HIV is prevention focused. Due to the paucity of empirical research on African American HIV positive women specifically, several generalizations had to be made regarding co-morbidity, spirituality, and treatment options within a socio-behavioral context.

The final article, Critical components: A review of interventions designed for co-morbid HIV positive women, examines outcome studies of psychosocial interventions and describes their components and effectiveness to determine the applicability and replicability of the interventions a treatment options for co-morbid African American women. A total of fifteen articles met search criterion and were categorized by stress and coping models and behavioral interventions to reduce anxiety among HIV positive women. They consisted of spirit-level group interventions, individual therapeutic

techniques, community collaboration models, and stress management. Components of the interventions that could be useful when developing spiritual interventions for African American women were identified.

Directions for Future Research

Several directions have surfaced as opportunities for future research in this area. First the development of more intervention studies focused on the unique coping strategies of African American women is warranted. Comparison studies can provide insight into the racial/ethnic differences in coping strategies among women living with HIV. Much of the literature reported on women living with HIV and African American women living with HIV present samples with a majority of participants having lower level income, if any. This may be due to increased data collection in community clinics and organizations that serve low income areas. Additional information regarding socioeconomic status and education level may also be beneficial in developing relevant psychosocial interventions for subgroups within the population.

Identification of various psychosocial stressors and subsequent coping strategies within subgroups of women living with HIV, i.e., mothers, employed women, different racial/ethnic groups, substance abusing women, stratified age groups (18-35, 35-55, 55+), stratified socioeconomic status, and partnered/married women can also contribute new knowledge to the landscape of intervention targets. Within the context of spiritual coping, further research can explore the use of clergy and religious supports in coping with stressors related to HIV. Additionally, more studies on the effectiveness of spiritual

behavioral activities (such as mantram, Tai Chi, or spiritual reflection) in HIV positive women and comparatively in African American women will broaden available intervention techniques for the population.

Implications for Social Work Education and Practice

Growing interest among social work practitioners has resulted in increased research on spirituality and religion, however, there have been few, if any studies exploring the profession's level of spiritual sensitivity (Hodge, 2006). One survey utilizing a random sample of licensed social workers expressed generally positive attitudes toward the role of religion and spirituality in practice (Sheridan, 2004). Conversely, this same study, consistent with other findings in literature, highlights that spirituality and the recognition of faith groups are nearly invisible in social work education text and empirical research (Hodge, 2006, Sheridan, 2004). Little is known about the proportion of social workers that refer clients to pastoral counseling upon request, assessment, or when the client need is outside of the worker's scope of practice. Additionally, further study is needed to determine the proportion of social workers that include spirituality scales in initial client assessments. Spiritual assessment is necessary to identify the effect of client's spirituality on service provision and client care and to accomplish appropriate treatment and discharge planning.

Concerns have been raised in various areas regarding the inclusion of religion and spirituality in social work curriculum and practice, such as possible conflict with the mission of social work, the NASW code of ethics, separation of church and state, client's

beliefs, and the social worker's beliefs (Barker, 2007; Dudley & Helfgott, 1990; Hodge, 2002; Hodge, Baughman, & Cummings, 2006; Stewart, 2009; Svare, Hylton, Albers, 2007; Tangenberg, 2005). Several scholars have presented options for inclusion of religion and spirituality in social work curricula. Canda (1989) proposed a comparative approach to the study of religion in social work education, highlighting that various religious perspectives be considered without promoting one religion over another. Netting, Thibault, and Ellor (1990) have explored religious institutions, affiliated organizations, and congregations for incorporation into existing courses in social work policy, organization, administration, and community practice. Ai (2002) and Sheridan (2000) provide discourse on the definitions of spirituality and its benefit to professional education. There is also literature on studies of social workers' (Furman, Benson, Grimwood, & Canda, 2004; Gilligan & Furness, 2006), students' (Gilligan & Furness, 2006; Graff, 2007; Sheridan & Hemert, 1999), and faculty's (Sheridan, Wilmer, & Atcheson, 1994) views on the inclusion of content on religion and spirituality in the social work curriculum. Additionally, comparison studies have also been conducted to identify similarities and differences in social worker and client beliefs (Hodge, 2002) as well as views on the incorporation of religion and spirituality in social work practice (Gilbert, 2000).

One half century ago, Spencer (1961), affirmed that social work practice includes work with persons, groups, and institutions for whose knowledge of spiritual and religious matters is an essential component of life. She contended that this knowledge

cannot be acquired without professional education and proposed that "it is appropriate for such educational content to be included as a part of the regular professional curriculum for social work (p. 170)." Several authors have since pointed out that the topics of religion and spirituality are still neglected in social work education (Barker, 2007, Canda, 1989; Dudley & Helfgott, 1990; Gilligan & Furness, 2005; Sheridan, Wilmer & Atcheson, 1994; Sheridan & Hemert, 1999; Siporin, 1986). A debate continually ensues comparing issues of the appropriateness of including religious beliefs in a helping relationship free from moral judgment, and the recognition of spirituality as a fundamental part of the human condition and, as such, inherent in the social work setting (Rice, 2002; Stewart, 2009).

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