PSYCHOSOCIAL AND SPIRITUAL FACTORS AFFECTING
PERSONS LIVING WITH HIV AND AIDS

DISSERTATION

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The purposes of this study were (a) to examine whether social support decreases as the person with HIV disease progresses from asymptomatic HIV to symptomatic AIDS and (b) to examine the extent to which general well-being might be mediated through a religious and/or spiritual support system.

Fifty-three persons with HIV disease completed a demographics questionnaire, the Spiritual Well-being Scale (SWBS), the Index of Core Experiences (INSPIRIT), and a measure of social support. Based on previous literature that shows social support to decline and spirituality to take on greater relevance as one becomes increasingly debilitated by chronic or terminal disease, it was hypothesized that persons with asymptomatic HIV would report greater levels of emotionally-sustaining social support than those with symptomatic AIDS. It was also hypothesized that spiritual measures would reveal greater spiritual well-being in persons with symptomatic AIDS than in those at the asymptomatic stage of the disease.
Despite statistically non-significant findings related to the formal hypotheses, correlational analyses of subcategories of the social support scale and the measures of spirituality did provide several clues to psychosocial changes that occur as one progresses from asymptomatic HIV to symptomatic AIDS. Availability and frequency of use of social supports were perceived differently as one moved from the asymptomatic stage to the symptomatic stage of HIV disease.

Correlational analyses of social support and indices of disease progression indicate that as one progresses toward AIDS, the perception of social support availability and use diminishes while perceived usefulness of such support (if it were available) is perceived as more valuable.
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INTRODUCTION

Researchers have suggested that psychosocial factors may affect Human Immunodeficiency Virus (HIV) infection and subsequent disease progression (Keicolt-Glaser & Glaser, 1988; Solomon & Temoshok, 1987). The psychosocial and spiritual toll of HIV and Acquired Immunodeficiency Syndrome (AIDS) affects those individuals with the virus in a variety of ways, including: social isolation, avoidance by others, discrimination, stigma, loss of control, self-doubt, and spiritual or existential crisis (Carson, Soeken, Shanty, & Terry, 1990; Flaskerud, 1987, 1989; Fortunado, 1987; Hays, Chauncey, & Tobey, 1990; Longo, Spross, & Locke, 1990; McDonnell, Abell, & Miller, 1991; Nyamathi & van Servellen, 1989; Rounds, 1988; Wendler, 1987). Such psychological consequences place the individual with HIV or AIDS at greater risk for psychological and medical complications (Hays et al., 1990).

HIV disease follows an uncertain path; the durations of the disease, exacerbations or onset of opportunistic infections, and treatment methods are all uncertain variables (Wendler, 1987). Living with constant uncertainty and vulnerability can often produce feelings of apathy, passivity, and surrender to the disease, similar to Seligman's model of learned helplessness. Individuals
experiencing a lack of personal control over their lives may turn to religion to regain some degree of control (Koenig, George, & Siegler, 1988). Enhancement of personal control through: (a) dietary changes, (b) personal development, (c) involvement in political and social activities related to HIV/AIDS, (d) sharing of experiences through research participation or speaking at educational forums, and (e) spiritual activities is believed to represent a survivor’s attitude and are linked to longer-term survival (Carson et al., 1990; Moulton, Sweet, & Temoshok, 1990; Namir, Wolcott, Fawzy, & Alumbaugh, 1987).

It has been suggested that psychosocial and spiritual needs of persons living with HIV disease change as the disease progresses from asymptomatic HIV to symptomatic AIDS (Hays, Turner, & Coates, 1992); therefore, the psychosocial and spiritual resources necessary to deal effectively with the various stressors presented at different stages of the disease progression will also be expected to change. This study is an attempt to better understand the spiritual and psychosocial strategies available to and used by persons with HIV disease (PWHs) as the disease progresses from asymptomatic HIV to symptomatic AIDS. The information provided by this study may assist in development of effective psychosocial and spiritual interventions specific to these populations.
Issues in Health, Illness, and Spirituality

The World Health Organization no longer considers health to be the mere absence of disease, but instead defines it as a state of complete physical, mental, and social well-being. Others (Dunn, 1979; Michello, 1988; Tubesing, 1979) in the health sciences have argued for a broader definition of health that includes the mind, body, spirit, and social context. Wellness, or holistic health, theories and research discuss the mind, body, and spirit as a single, inseparable entity (Achterberg, 1985; Dossey, Keegan, Kolkmeier, & Guzzetta, 1989; Reisser, Reisser, & Weldon, 1983). Positive relationships between the level of psychological, social, and/or spiritual balance and physical health have been suggested in the literature (Colliton, 1981; Dossey & Keegan, 1989; Gibbs & Achterberg, 1978; Hiatt, 1986; Kass, Friedman, Leserman, Zuttermeister, & Benson, 1991; Ruberman, Weinblatt, Goldberg, & Chaudhary, 1984). Weil (1983) defined health as a positive balance between an individual's internal states of physiological, psychological, and spiritual existence and external forces of biological, social and environmental circumstances. The delicate balance between these forces may be easily disrupted in times of illness and/or stress; when one variable is out of balance, all others are affected.

Colliton (1981) proposes that critical illness affords many individuals the first opportunity to explore their
spirituality. The crisis of terminal illness redirects one's thoughts away from materialistic pursuits and toward a search for meaning and purpose in life. This soul-searching becomes, somehow, more acceptable in light of physical disability and/or death. Denial has been suggested as a temporary defense mechanism that may forestall acceptance of serious illness and would therefore delay exploration of spiritual or existential issues, particularly with early diagnosis in asymptomatic individuals (Carson et al., 1990). Belcher, Dettmore, and Holzemer (1989) point out that when illness, loss, physical limitation, or suffering destroy one's sense of security or immortality, the resulting loss of control may result in some type of spiritual event. Religious coping behaviors, particularly exemplified by "placing trust or faith in God, praying, and obtaining help and strength from God" are believed to take on greater relevance in situations where other coping strategies have failed or are believed to be futile or unavailable (Koenig et al., 1988). In instances where health/illness events are beyond control of the individual, it is believed to be more adaptive to surrender control to a powerful other (e.g., a physician, God, or Higher Power) rather than experiencing repeated personal failure (Affleck, Tennen, Pfeiffer, & Fifield, 1987).

Distinctions between definitions of spirituality and social support will be clarified and subsequently discussed
as they have been shown to relate to various illness processes. Social support and spirituality have been postulated as buffers to assist the individual in adapting to the stresses associated with illness and hospitalization in various populations experiencing illness or injury. These will be discussed in the following sections. Despite a literature postulating the efficacy of each of these constructs as stress-buffers, empirical research examining the interrelationship between spirituality and social support in health and illness is lacking. This void may be due to the difficulties related to defining the construct of spirituality.

Definitions and Distinctions Between Spirituality and Religiosity

Spirituality and religiosity are often used interchangeably, but there are subtle differences that are important to the study of these phenomena. Seaward (1991) states that one can be spiritual without being religious or be religious while having limited awareness of the spiritual dimension of existence. Granstrom (1985) points out that spirituality is not restricted to participation in any type of organized religion as it involves a broader concept than religiosity. Seaward (1991) characterizes spirituality as a "living process of learning about oneself, unlike ‘being religious’ in which this process is shared with others in an
organized fashion". Seaward goes further by stating that religion can even obstruct the growth of the human spirit.

Spirituality has been defined as (a) the central philosophy of an individual's life that guides personal behavior, including one's desire to understand the meaning of life, death, and illness (Moberg, 1971), (b) "the process of learning about oneself and one's personal value system and applying this knowledge to the pursuit of one's meaningful purpose in life" (Seaward, 1991, p. 166), and (c) beliefs and behaviors that represent a sense of relatedness to a transcendent dimension, being, power, or force that is greater than the self (Farran et al., 1989; Reed, 1987).

Religion, on the other hand, is said to be (a) something created by people (Belcher et al., 1989) that (b) comprises "the social activities of a church group, cult, or occult" (Seaward, 1991) and/or (c) involves the active application of a specific unified system of organized rules, practices, and guidelines associated with a religion or denomination (Farran et al., 1989; Hoyman, 1966). Since social activities may be a part of church participation, the differences between spiritual or religious well-being and perceptions of social support may become blurred.

Investigation of spirituality has traditionally been relegated to the realms of philosophy and religion because of its abstract and subjective dimensions (Chapman, 1987). "Human spirituality is a multi-faceted and complex matter
that defies precise definition and seems to elude rigorous analysis and understanding" (Benner, 1991, p.3). Due to these difficulties, scientific examination of this phenomenon has been limited. Farran and associates emphasize the complexity in defining a construct such as spirituality since it involves an individual's subjective experience which is influenced by "their own culture, development, life experiences, and organization of ideas about life" (Farran, Fitchett, Quiring-Emblen, & Burck (1989, p.187). Despite the difficulties involved with studying the spiritual dimension, Carson et al. (1990, p.28) emphasize the importance of research that will assist in the strengthening "of the spirit and psychological resiliency of afflicted individuals".

**Definitions of Spiritual Well-being**

Spiritual and/or religious well-being have been proposed as important factors in the mediation of illness. Religious or spiritual attitudes and behaviors have been suggested as stress buffers which assist the individual in coping in difficult circumstances (Koenig, et al., 1988). Ellison (1983) defined the construct of spiritual well-being as a complex construct made-up of (a) a religious component relating to one's relationship with God and (b) a socio-psychological or existential component that is related to life-purpose and satisfaction outside of a religious context. The National Interfaith Coalition on Aging (1975) loosely
defined spiritual well-being as: "the affirmation of life in a relationship with God, self, community, and environment that nurtures and celebrates wholeness." These interconnected aspects of relationship with God or a Higher Power and the social or community aspect found in almost every definition of spiritual content must be considered together in order to understand the disease process; it is this interconnectedness that makes precise definition of these constructs for empirical study difficult.

Religiosity and Illness

Religious beliefs and practices have been suggested to aid the individual’s ability to maintain a sense of well-being in the wake of physiological and perceptual losses associated with terminal illness (Reed, 1987). Several studies with critically ill individuals have supported this proposition. Hospitalized patients who expressed intrinsic religious orientation were shown to exhibit greater emotional adjustment than patients with external or no religious orientation (Carey, 1974). Cancer patients who derived emotional support from the church were found to experience less sleep difficulty than other patients who did not rely on the church (Gibbs & Achterberg-Lawlis, 1978). Acklin, Brown, and Mauger’s (1983) research supported their hypothesis that transcendent meaning, religiosity, and church attendance related positively to coping in cancer patients. Research with female cancer patients suggests
that women tend to be more likely than men to believe religious practice can affect disease course (Watson, Green, Pruyn, & Van Den Borne, 1990). Frequent attendance at religious services was associated with reduced reporting of feelings of isolation and withdrawal by cancer patients (Acklin et al., 1983). Reed (1987) found reports of religiousness to be greater in terminally ill outpatients who believed they were close to death. She also found terminally ill, adult, female patients to report greater religiosity than male patients (Reed, 1986).

Spirituality and Illness

Instances involving illness, loss, or hospitalization often precipitate one’s consideration of values, human limitations, sense of control, and significance, meaning, and/or purpose in life (Belcher et al., 1989; Millison, 1988; Stoll, 1979). The spiritual needs of persons with terminal or chronic illness involve the presence of, or perception that, one has loving and reciprocal relationships with others (Clinebell, 1966; Epperly, 1983). The quality of social support one perceives can either enhance or impair the spiritual experience (Belcher, et al., 1989). Participation or connectedness with a “community of shared faith” has been suggested as a source of affirmation or social support for persons experiencing illness (Parran, et al., 1989). These authors suggest that health enhancing support received from this community is mediated by the
ability of the individual to share health-related concerns or issues with the community and the community's openness to sharing these issues amongst themselves. Based on the above considerations, it must be admitted that spiritual or religious participation or fellowship may confound research findings regarding specific distinctions between spirituality and social support.

Reed's (1987) study comparing hospitalized patients with and without terminal illness and a control group of non-hospitalized healthy persons showed that the terminally ill group reported greater spirituality than other hospitalized patients or healthy controls. Research with the Spiritual Well-being Scale (SWBS) in physically ill populations has revealed positive correlations between scores on the SWBS and (a) adjustment to the stress of hemodialysis in patients with renal failure (Campbell, 1988) and (b) physical, emotional, and spiritual health in persons with AIDS (Carson et al., 1990). Negative correlations have been found between SWBS scores and reported amount and frequency of pain and degree of impairment seen in cancer patients (Ellison & Smith, 1991), (b) anxiety in cancer patients (Kaczorowski, 1989), and (c) elevations in blood pressure (Hawkins, 1986).

Religion and Persons with HIV/AIDS (PWH/PWAs)

Religious issues encountered by the person with HIV or AIDS (PWH/PWA) may differ depending on the route of disease
transmission; those who are homosexual or bisexual may experience reactions from the church that prevent fulfillment of existential spiritual needs (Carson, et al., 1990). Although religious communities have traditionally come to the spiritual and social assistance of individuals and their families in times of illness, injury, or death, this may be less true when the victim of the tragedy is believed to have brought on the problem himself (Kayal, 1985).

Levin and Schiller (1987) suggest that religious practices/beliefs may be detrimental to psychological and/or physical wellness by creating or increasing guilt and/or anxiety in those who feel they are unable or have failed to follow the moral teachings of the church. Many religious people believe that straying from the teachings of the Bible or intentional disobedience to God may lead to punishment (Bearon & Koenig, 1990; Roberson, 1985; Solomon, 1989) or that sinfulness opens the individual to assaults from the Devil (Roberson, 1985). Wendler (1989) found that many PWA's experience feelings of confusion and insecurity over the true essence of God as punishing and vengeful or loving and forgiving. When passages from the Bible are interpreted as condemnation of homosexuality, gay individuals experience strong emotions of anger over the twisting and misuse of the word of God or great inner distress and self-doubt. Either way, these interpretations have driven many homosexual
individuals away from the church through bitter disappointment, anger, or as a self-protective way of reducing cognitive dissonance (Carson et al., 1990; Fortunado, 1987; Kayal, 1985; Kirkpatrick, 1990; Tibesar, 1986).

Spirituality and Persons with HIV/AIDS (PWH/PWAs)

Some PWAs have expressed a desire, but an inability, to find some internal sense of hope or empowerment to help foster their strength to continue to fight the progression of the disease (Macks, 1987), while others have reported spirituality as a factor that has enhanced their ability to cope with the illness by allowing them to hope for a positive health outcome (Nyamathi & van Servellen, 1989). Carson et al. (1990) suggest that many gay PWAs bypass the traditional structure of the church due to "religious and social isolation, and public discrimination and condemnation". Instead, these PWH/PWAs seek their spiritual answers from the broader base of spirituality found outside of organized religion (Fortunado, 1987). In a study comparing results on the Spiritual Well-being and Beck Hopelessness Scales, gay men with AIDS were shown to have significantly greater correlations between Existential Well-being and Hopefulness than Religious Well-being and Hopefulness (Carson et al., 1990).

The foregoing research indicates that religious and/or spiritual attitudes/behaviors serve as stress buffers and...
thereby assist the individual in coping with life-threatening circumstances. Religious and/or spiritual coping behaviors are believed to take on greater relevance in situations where other coping strategies have failed or are believed to be futile or unavailable (Koenig et al., 1988). Therefore, it appears that religious and/or spiritual practice could become a more central part of one's coping strategy as HIV progresses to AIDS and begins to manifest life-threatening complications. Warner-Robbins and Christiana (1989, p. 46) suggest that the "finality" of an AIDS diagnosis will encourage one to consider previously unexplored issues in life and draw the PWA "even closer to their spiritual beliefs" while those with asymptomatic HIV may still be able to temporarily deny the ultimate outcome of the diagnosis and the issues that it evokes.

Social Support

Social support has been shown to be an influential factor in buffering individuals from the negative health effects created through stress (e.g., Berkman, 1985; Heller, Swindle, & Dusenbury, 1986; Holahan, Holahan, Moos, & Brennan, 1991; Lin, Simone, Ensel, & Kuo, 1979) as well as being linked to the recovery and/or coping processes of physically ill or injured patients (e.g., Blythe, 1983; DiMatteo & Hays, 1981; Wortman, 1984; Wortman & Conway, 1985). However, no single definition of social support has been used by researchers.
Several review articles (e.g.: Lindsey, Norbeck, Carrieri, & Perry, 1981; McGough, 1990; Pearson, 1986; Wortman, 1984) provide thorough summaries of the major components that make up the construct called social support. These social support components include: (a) feelings of love, (b) a sense that others care about them, (c) that one is respected or esteemed, (d) feelings of belongingness in a group, (e) faith that one will receive material or financial assistance in times of need, (f) trusting that advice and information will be shared freely, and (g) a notion that the relationship is based in common need and that one might repay or reciprocate the assistance when another is in need.

Provision of social support has been related to speed and degree of recovery (Fontana, Kerns, Rosenberg, & Colonese 1989) and increased longevity (Ruberman et al., 1984) in medical patients while those patients experiencing high levels of isolation and stress had a higher mortality rate than those low on these factors. Kulik and Mahler (1989) found surgical patients who were married and received consistent visitation required lower levels of pain medication than less visited married patients. Wilson-Barnett (1981) found that cardiac patients returning home to a caring spouse reported a more rapid recovery than unmarried or widowed patients.

Heller et al. (1986) suggest that health related outcomes are not a direct effect of social support, but
rather that the individuals' perceptions or appraisals of the positive or negative value of the support offered may assist in buffering stress or bolstering ability to cope with illness. The stress-buffering effect of social support may only be valued to the degree that the social support provided matches the demands placed on the individual by the stressor (Cohen & McKay, 1984); thus, if the individual desires a specific type of social support but receives assistance of a different type, the help-intended behavior may prompt a negative evaluation by the recipient (Cutrona, Cohen, & Igram, 1990).

Perceived helpfulness of support has been found to be dependent on what type of support was provided by whom. The various types of social support are delivered through social support networks that consist of family, friends, work associates, group affiliations, and health care professionals (House & Kahn, 1985; Wills, 1985). In a study of social support in women living with chronic illness, Primomo, Yates, and Woods (1990) found women to report the greatest receipt of all types of social support from a spouse/partner. Men, in general, have been shown to have fewer social support resources than women, and are less likely to seek or receive support from anyone, other than a spouse, in times of crisis (Chappell, 1989; Shumaker & Hill, 1991). Hays et al. (1990) found that peer relations were perceived as more supportive than support from family
members in gay men with AIDS. These authors report that PWA’s, in general, have tended to seek assistance first from friends, then from medical professionals, from partner or spouse, and finally from others living with AIDS. In a study comparing racial differences in gay men with HIV, it was found that gay white men rely more on gay friends and gay community resources for support, while gay black men were more likely to seek/obtain social support from family and friends outside the gay community (Ostrow et al., 1991).

Racial, gender, and cultural differences between groups of HIV+ individuals may result in significantly different needs for and perceived availability of social support. Generally, incidence of illness appears to be greater in those lacking adequate social support, and the association between social support and illness is greater in women than men (Schwarzer & Leppin, 1989). Further investigation of differences in social support availability and receipt in gay versus straight men and women of all ethnic or cultural backgrounds is needed, particularly as they relate to social support networks of persons living with HIV or AIDS.

Social Support and Persons with HIV/AIDS (PWH/PWAs)

Individuals with AIDS or HIV often experience an actual or perceived lack of social support. Wortman and Dunkel-Schetter (1987) hypothesize that conflicting emotions in members of the support network may lead to inconsistent or inappropriate provision of support. These authors suggest
that initial feelings of fear and aversion to the disease (cancer in their studies) combine with social and moral feelings of obligation to produce ambivalent feelings of which the patient may become aware. Such feelings may be conveyed to the PWH/PWA through uncomfortable social behavior such as forced cheerfulness, avoiding the topic of the illness or minimizing the magnitude of it, or simply withdrawing from frequent or continuous contact with the patient (Wortman & Dunkel-Schetter, 1987). These circumstances may be particularly pertinent to the individual with HIV or AIDS due to the additional associations involving fear of contagion (Conlon, 1991; Longo et al., 1990; McDonell et al., 1991; McGough, 1990; Rounds, 1988; Wendler, 1987) and societal feelings regarding homosexuality, drug abuse (Flaskerud, 1989; Librach, 1987; McDonell et al., 1991; Nyamathi & van Servellen, 1989; Rounds, 1988), or promiscuous sex. Research has suggested that psychosocial functioning may be impaired in those persons who live outside of the accepted values and norms of their prevailing social support network (Abbey, Abrams, & Caplan, 1985; Ostrow et al., 1991). Also, members of communities hardest hit by HIV/AIDS may withdraw due to "bereavement overload" or burnout, leaving a depleted or nonexistent peer support group for PWH/PWA's (Hays et al., 1990).
In instances where PWAs have been fortunate enough to exist within a loving and accepting environment, studies have shown greater coping ability and ratings of greater life satisfaction as well as decreased symptom reporting. Namir et al. (1987) found that PWAs who expressed satisfaction with their support group exhibited more active-positive coping strategies resulting in more positive perceptions of health and self-esteem and a decreased occurrence of affective symptoms such as depression or anxiety. Remien, Rabkin, Katoff, and Williams (1991) found long-term AIDS survivors reported taking an active and informed role in treatment decisions and attributed their exceptional survival to both internal (positive attitude, will to live, good self-care) and external factors (good medical care, social support). Namir, Wolcott, and Fawzy (1989) found that PWAs who reported satisfaction with their support networks experienced less physical pain and rated the quality of their lives more positively than those who were unhappy with their social networks. Zich and Temoshok (1987) reported that individuals with AIDS or ARC who perceived social support to be readily available experienced less hopelessness and depression. In a study of 53 PWAs considered to be long-term survivors, Remien et al. (1991) found life satisfaction to be positively related to a supportive social network and negatively related to social conflict. In addition, a high correlation between
psychological well-being and ability to reciprocate social assistance has been documented in gay male PWAs (Hays et al., 1990); these authors postulate enhanced self-esteem and an escape from the sick-role are at the basis of this finding.

Social support has been shown to be an influential factor in buffering individuals from the negative health effects created through stress (e.g.: Berkman, 1985; Heller, Swindle, & Dusenbury, 1986). In addition to everyday stressors and the stress experienced as a result of any type of illness, persons with HIV or AIDS appear to be at greater risk of social isolation secondary to societal fears regarding contagion (Conlon, 1991; Longo et al., 1990; Rounds, 1988) and/or stigma related to presumed membership in a high-risk group (Flaskerud, 1989; Namir et al., 1989; Nyamathi & van Servellen, 1989). Based on previous findings concerning the importance and provision of social support, it was believed that investigation into the intricacies of support systems of persons with HIV and AIDS would render valuable information which could be used to improve utilization of resources by these populations.

Spiritual Versus Social Relationships

Pollner (1989) suggests that individuals may imagine or perceive relationships with figures that do not exist in the concrete world, but are, instead, personified by the individual to engage in supportive interactions such as
providing guidance, acceptance, or solace. When these figures are believed to be developed from or related to religious study or practice, Pollner refers to them as "divine relations" (p.92). A limited body of research has shown that spiritual experiences or divine relations are reported by a significant percentage of the population (Davis & Smith, 1986; Pollner, 1989; Thomas & Cooper, 1978) and may contribute positively to physical and/or psychological health (Benson, 1975, 1987; Bowen, Justyn, Kass, Miller, Rogers, Rogers, & Wood, 1978; Kass, Friedman, Leserman, Zuttermeister, & Benson, 1991). Pollner (1989) hypothesized that divine relationships could create the same beneficial effects on psychological well-being as has been shown in psychological literature investigating actual or concrete social relationships.

Pollner (1989) suggested increased usefulness of divine relationships in those persons who are socially isolated. Based on literature suggesting that as one becomes progressively debilitated by chronic or terminal disease and that spiritual beliefs and practices are increased as one nears death, it might be proposed that as one’s concrete social network diminishes, spiritual or divine relationships develop to sustain the individual’s overall psychological and physical well-being, particularly in times of health crisis.
Conceptualization of Research Problem

Holistic health, or wellness, has been defined as a combination of physical, psychological, spiritual, and social factors (Michello, 1988; Weil, 1983), yet Farran et al. (1989) note that the study of spirituality is often considered to be of less significance than that of physiological, psychological, and sociological aspects. The majority of research in the behavioral sciences has limited the focus of studies on health to more easily defined and objectively measurable constructs such as social support and psychological distress. While these constructs are of great importance to increased understanding of coping with chronic or life-threatening conditions, the spiritual dimension is believed to play an equally valuable part in this process of coping. Psychological and physical health outcomes are believed to be influenced by perceived availability and usefulness of social support and faith in a Higher Power or God. Literature exists which suggests persons with HIV and AIDS have been ostracized by traditional social and spiritual networks due to their actual or perceived participation in socially and/or morally stigmatizing activities, particularly gay, bi-sexual, or sexually promiscuous lifestyles and/or intravenous drug abuse. Additionally, researchers have noted a tendency for social supports and contacts to diminish as chronically or terminally-ill persons near death and for those who believe
themselves to be closer to death to report increased spiritual or religious practice or faith.

The major goal of this study was to further explore the social and spiritual factors existing in persons with HIV and AIDS at different stages of disease progression. The specific purpose of this research was to examine whether social support decreased as the individual with HIV disease progressed from asymptomatic HIV to symptomatic AIDS and to what extent overall well-being, might be mediated by replacement of the concrete social support network with a religious or spiritual support system if social support was, in fact withdrawn. Existential, religious, and spiritual well-being was examined through use of Ellison's (1983) Spiritual Well-being Scale (SWBS). A belief in the existence of a Higher Power or God and one's ability to experience a relationship with their image of God was examined through responses to The Index of Core Experiences Scale (INSPIRIT; Kass, et al., 1991). Desirability, perceived availability, frequency of use, and perceived usefulness of emotionally-sustaining, problem-solving, indirect personal influence, and environmental action types of social support were examined using a modified version of Zich and Temoshok's (1990) social support scale. The independent variable was group membership: HIV+ or AIDS. Dependent variables were scores on the two measures of spirituality and the social support scale. It was predicted
that there would be an inverse relationship between scores on the social support measure and scores on both the SWBS and INSPIRIT scales; it was expected that this relationship would be stronger in the AIDS group as these individuals would be at the point of their illness where previous research has suggested that social supports begin to withdraw or diminish in efficacy and spirituality begins to take on greater relevance.

Hypotheses

(1) Persons who are HIV+, but asymptomatic, will report significantly greater levels of emotionally-sustaining social support compared to persons with symptomatic AIDS.

(2) Spiritual, Religious, and Existential Well-being scores, as measured by the Spiritual Well-being Scale (SWBS), will be greater in those persons with symptomatic AIDS than in those with asymptomatic HIV.

(3) Scores on The Index of Core Experiences (INSPIRIT) will be greater in those persons with symptomatic AIDS than in those with asymptomatic HIV.

METHOD

Participants

Surveys were distributed through agencies providing services or support to persons with HIV or AIDS. These agencies included: the Dallas County Public Health Department, Fort Worth Community Outreach Center, San Antonio AIDS Foundation, Women’s Counseling Center, Project
W.I.S.D.O.M., Harvest Metropolitan Community Church, Most Holy Redeemer AIDS Support Group, and private therapists. Approximately 375 were distributed and 53 of these were completed and returned. Only persons who had previously received a positive test result for HIV were accepted for study participation. The population was then divided into two groups: (a) those who were HIV+ but asymptomatic and (b) those who had experienced one or more AIDS-related opportunistic infections and/or had a CD4 count of less than 200. Participants had to be literate in printed English in order to read through and comprehend the survey questions.

Measures

Demographics. The Demographics Questionnaire (see Appendix B) was used to gather information on age, gender, ethnicity, education, occupation, financial support, living situation, relationship status, sexual orientation, time since diagnosis with HIV/AIDS, possible HIV transmission routes, and data regarding religious affiliation, and spiritual practices or beliefs. A CD4 count of less than 200 is the Center for Disease Control’s defining characteristic of AIDS. Since HIV infection is marked by a gradual decrease in CD4 cells as the virus progresses toward AIDS, participants were asked to record their most recent CD4 count as a marker of illness progression or severity.

Spirituality. Spirituality was measured by The Index of Core Experiences (Kass et al., 1991) and the Spiritual
Well-being Scale (Ellison, 1983). Other factors related to religious or spiritual practice were collected via the demographics questionnaire sections regarding: (a) belief in God or a Higher Power, (b) attendance of worship services, and (c) prayer, meditation, or contemplation of spiritual materials outside of traditional worship services.

The Index of Core Experiences (INSPIRIT), a scale consisting of seven items which examine distinctive events or experiences resulting in cognitive appraisals that (a) convince one that God or a Higher Power exists and (b) one may experience a close relationship with their image of God, was also used to examine a belief in God on a "more concrete than an amorphous" level (Kass et al., 1991, p. 204). Most responses were rated on a 1-4 scale with an additional option of 0 for "can't answer" on items 1, 3, 4, and 5. Item seven provided a list of spiritual experiences and asked the participant to indicate whether they had experienced each, and if so, to what level it convinced them of the existence of God or a Higher power or strengthened their belief in God or a Higher Power; the highest item score marked on this list was used as the response for item seven. Values for all items were summed and divided by 7 to get the INSPIRIT total. Initial study of this scale yielded a Cronbach’s Alpha reliability coefficient of .90. Correlation of the INSPIRIT with the Intrinsic scale of
Allport and Ross’ Religious Orientation Inventory was 
(r = .69, p < .0001).

Ellison (1983) suggested that the construct of 
spiritual well-being consists of (a) a religious component 
relating to one’s relationship with God and (b) a socio-
psychological or existential component that is related to 
life-purpose and satisfaction outside of a religious context 
(Carson, Soeken, & Grimm, 1988). The Spiritual Well-Being 
Scale (SWBS) was responded to by circling one of six choices 
that best indicated the subject’s degree of agreement with 
each of 20 statements reflecting feelings of religious or 
existential/psychological well-being. Items were scored 
from 1-6 with reversal of scores for negatively worded items 
such that higher scores indicated greater well-being. Ten 
items assessed Religious Well Being (RWB) and the remainder 
measured Existential Well Being (EWB). The sum of these two 
subscales (RWB and EWB) reflected an overall measure of 
Spiritual Well Being (SWB). Test-retest reliability 
coefficients, as reported by Paloutzian and Ellison (1982), 
are .96, .86, and .93 for RWB, EWB, and SWB respectively. 
Coefficient alphas were .87 (RWB), .78 (EWB), and .89 (SWB), 
indicating a high degree of internal consistency. This 
measure was previously used in a study of persons with HIV 
and AIDS (Carson et al., 1990) and proved to be a reliable 
indicator of religious (coefficient alpha = .92), 
existential (coefficient alpha = .93), and spiritual well-
being (coefficient alpha = .94) for this group of 65 adult male patients.

The socio-psychological or existential component of this measure is a face valid measure for depression which may confound the measurement of spirituality by suggesting that the absence of EWB is depression and, conversely, that the absence of depression indicates that one is existentially well. Michello (1988) supports Ellison’s view of Existential Well-being that exists on a continuum between positive and negative affect. Fehring, Brennan, and Keller (1987) found negative correlations between the Spiritual Well-Being Scale (SWBS) and Beck Depression Inventory as well as six scales of the Profile of Mood States which measure negative affect. Ellison (1983) reports negative correlations between the SWBS and (a) Frankl’s Purpose in Life Test and (b) Russell and Cutrona’s UCLA Loneliness Scale. A negative correlation between spiritual well-being and loneliness and positive correlations between spiritual well-being, self-esteem and social skills were reported by Paloutzian and Ellison (1982).

Social Support. The construct of social support was assessed with a measure adapted from Zich and Temoshok (1990) which was based on the content-analytic work of Gottlieb. Gottlieb (1978) proposed four categories of informal help or support: (a) emotionally sustaining behavior, (b) problem-solving behavior, (c) indirect
personal influence, and (d) environmental action. The original version of the questionnaire consisted of 8 statements which were scored on a 1-5 scale on 4 categories: desirability, availability, frequency of use, and usefulness. The original version of this social support rating scale was modified to a sentence format consisting of 32 statements for ease of self-administration.

Procedures

Participants received a packet containing: a cover letter describing the project and requesting participation (Appendix A), a demographics questionnaire (see Appendix B), two standardized measures of spirituality and a measure of social support adapted from Zich and Temoshok (1990; see Appendix C). Research packets were distributed by agency workers or volunteers during the Fall of 1992 and Spring of 1993.

A cover letter (see Appendix A) explained the research project. Participants were free to choose not to accept the packet or not to return it in the envelope provided. It was made clear that participation in the research project would, in no way, affect the services provided by the agency or counselor distributing the packet. Those who chose to participate were given the option to complete and return the survey on site or to take the survey home for completion and return it via a business reply envelope. A second letter (Appendix D) was placed at the end of the packet; the
purpose of this letter was to recruit participants for a second, follow-up study which will collect similar data to that in this study at 6, 12, and 18 month intervals.

RESULTS

Demographic Data

Despite distribution of research packets through two agencies providing services exclusively to women and through agencies who generally provide services to persons of color and/or lower socio-economic status, the majority of respondents were gay, white males with single incomes between $10,000 - 30,000 per year. Forty-six males and 7 females returned completed surveys.

HIV group. The HIV group consisted of 24 men and 5 women. The mean age of respondents in this group was 33.64 years with a range of 22-44 years. There were 20 Caucasians, 3 African Americans, 2 Hispanics, and 1 Native American, 2 others failed to indicate ethnicity. Twenty-four members of the HIV group identified themselves as homosexual, 3 as heterosexual, and 2 as bisexual. Mean length of time since HIV diagnosis for this group was 36.59 months with a range of 1-118 months. Mean CD4 count was 529.82 with a range of 220-1080 for HIV group participants.

AIDS group. Participants in the AIDS group were 22 men and 2 women. The mean age of respondents in the AIDS group was 36.25 years, with a range of 28-50 years. Twenty were Caucasian, 1 was African American, and 3 were Hispanic. Four
of the AIDS group participants identified their sexual identity as heterosexual, 19 as homosexual, and 1 as bisexual. Mean time since HIV diagnosis was 53 months with a range from 12-96 months. Mean time since diagnosis with AIDS was 19.18 months with a range from 3-80 months. The CD4 count for this group ranged from 0-196, with a mean of 97.78. See Table 1 for additional demographic data for HIV and AIDS groups.

The mean age of male respondents was 35.35 years with a range of 25-50. Of the male respondents, 37 were Caucasian, two were African American, four were Hispanic, one was Native American, and two failed to indicate ethnicity. Forty-two men identified themselves as homosexual, three as heterosexual, and one as bisexual. The majority of male participants had experienced higher education: 22 had "some college", 10 were college graduates, and six had graduate or professional degrees. Two of the males had less than 10th grade education and seven were high school graduates. Twenty-three males were employed full-time, 17 were unemployed, two were employed part-time, one was self-employed, and one each identified himself as a homemaker and a student.

The mean age of female respondents was 31.83, with a range of 30-34 years. Two were African American, three were caucasian, and one was Hispanic. One woman failed to
Table 1

**Additional Demographic Data By HIV and AIDS Group Membership**

<table>
<thead>
<tr>
<th></th>
<th>HIV Group</th>
<th>AIDS Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Educational Level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10th grade</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Some High School</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>High School Graduate</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Some College</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>College Graduate</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Graduate Degree</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td><strong>Employment Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>19</td>
<td>6</td>
</tr>
<tr>
<td>Part-time</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Self-employed</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Unemployed</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Student</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Annual Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below $10,000</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>$10,000 - $20,000</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>$20,000 - $30,000</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>$30,000 - $40,000</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>$40,000 - $50,000</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Over $50,000</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

(Table continues)
identify age or ethnicity. Four of the female respondents identified their sexual identity as heterosexual, one as homosexual, and two as bisexual. Three women were high school graduates, two had "some college", and two had graduate degrees. Four of these respondents were unemployed; two were employed full-time and one part-time.

<table>
<thead>
<tr>
<th>Living Situation</th>
<th>HIV Group</th>
<th>AIDS Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alone</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>With Spouse/Lover</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>With Parent(s)</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>With Children</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>With Other Family</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>With Friend/Roommate</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship Status</th>
<th>HIV Group</th>
<th>AIDS Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>15</td>
<td>11</td>
</tr>
<tr>
<td>Same-sex Partner</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Other-sex Partner</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
In the overall study population, mean length of time since diagnosis as HIV+ was 44.02 months with a range from 1-118 months. CD4 counts for this population ranged from 0-1083 with a mean of 331.08. Forty-three percent of participants lived alone, 27% with a spouse or lover, 10% with a parent, 12% with a friend or roommate, 6% with other family, and 2% with children. Forty-nine percent of participants were single, 37% in committed relationships with same-sex partners, 4% in committed relationships with an opposite-sex partner, while 8% were divorced and 2% widowed.

Ninety-four percent of the participants reported a belief in God or a Higher Power. The majority of participants (67%) did not attend regular (i.e.: weekly or monthly) worship services, yet 78% reported practice of spiritual activities outside of traditional worship services on a daily (47%), weekly (19.6%), or monthly (9.8%) basis. Eighty-four percent of participants reported growth or positive change as a result of their diagnosis. Seventy-six percent reported finding a positive meaning or purpose for contracting HIV or AIDS.

Most participants (53%) gave multiple responses regarding possible transmission route of their HIV disease. Thirty-six percent of all respondents attributed transmission of the virus to anal intercourse and/or oral sex. Eleven percent responded that anal or oral sex or
intravenous drug use could have exposed them to the virus, while one other added vaginal intercourse with a heterosexual partner to this list of possible transmission routes. One respondent each gave intravenous drug use, oral sex, and needle stick in a medical setting as the only possible transmission route while five others listed anal intercourse as the most likely route. One participant believed transmission may have resulted from either intravenous drug use, vaginal intercourse with a bisexual male, or a transfusion. Another attributed transmission to oral sex or to vaginal intercourse with either a heterosexual or bisexual male. One respondent suspected a blood transfusion for reasons other than hemophilia as the transmission factor, but also marked "unsure of route of transmission". Two participants responded only that they were unsure of the route of transmission.

Statistical Analyses of Formal Hypotheses

Due to limited response to the survey by female participants and no statistically significant differences between gender group means on dependent variables (see Table 2), hypotheses were analyzed using a MANOVA design of all respondents regardless of gender. It was hypothesized that persons who were HIV+, but asymptomatic, would report significantly greater levels of emotionally-sustaining social support compared to persons with symptomatic AIDS. In this study population, the MANOVA did not reveal
significant differences between groups on the measures of emotionally-sustaining social support (i.e.: someone to talk to, someone who understands, and someone who expresses confidence) and problem-solving social support (someone who advises, someone who will explain how they dealt with similar problems, someone to turn to if something is needed; Wilks’ Lambda = .945812, df 1 = 2, df 2 = 50, p = .248380; see Table 3). Additionally, MANOVA comparing HIV+ and AIDS group responses to overall social support categories of: Desire, Availability, Frequency of Use, and Overall Usefulness/Helpfulness of social support in various aspects of daily living revealed no statistically significant findings between groups (Wilks’ Lambda = .912143, df 1 = 4, df 2 = 48, p = .342037; see Table 3).

Due to previous findings regarding changes in patterns of spirituality/religiosity of hospitalized patients or persons with terminal illness, it was hypothesized that Spiritual, Religious, and Existential Well-being scores, as measured by the Spiritual Well-Being Scale (SWBS), and scores on the INSPIRIT would be greater in those persons with symptomatic AIDS than in those with asymptomatic HIV. MANOVA of the subscales of the SWBS by group did not show statistically significant differences between these groups (Wilks’ Lambda = .929774, df 1 = 3, df 2 = 48, p = .316770; see Table 4).
Table 2
Means and Standard Deviations of Dependent Variables by Gender

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Months Since</td>
<td>45.597</td>
<td>31.220</td>
</tr>
<tr>
<td>HIV Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CD4 Count</td>
<td>333.864</td>
<td>333.864</td>
</tr>
<tr>
<td>Desired SS</td>
<td>32.217</td>
<td>6.484</td>
</tr>
<tr>
<td>Available SS</td>
<td>28.674</td>
<td>6.815</td>
</tr>
<tr>
<td>Frequency of SS</td>
<td>28.109</td>
<td>7.258</td>
</tr>
<tr>
<td>Usefulness of SS</td>
<td>33.913</td>
<td>6.772</td>
</tr>
<tr>
<td>INSPIRIT</td>
<td>2.844</td>
<td>1.107</td>
</tr>
<tr>
<td>EWB</td>
<td>45.311</td>
<td>10.379</td>
</tr>
<tr>
<td>RWB</td>
<td>44.800</td>
<td>13.351</td>
</tr>
<tr>
<td>SWB</td>
<td>90.111</td>
<td>21.520</td>
</tr>
</tbody>
</table>

It should be noted that the differences in overall scores between the Existential and Religious Well-being scales completed by this population was not statistically significant ($t = .2720$, df = 51, $p = .3934$), while correlational analyses revealed significant positive
Table 3

Means and Standard Deviations of Social Support Category Totals by Group

<table>
<thead>
<tr>
<th></th>
<th>HIV Group</th>
<th></th>
<th>AIDS Group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Emotionally Sustaining</td>
<td>49.138</td>
<td>7.160</td>
<td>47.792</td>
<td>8.161</td>
</tr>
<tr>
<td>Problem Solving</td>
<td>44.517</td>
<td>8.505</td>
<td>45.208</td>
<td>7.740</td>
</tr>
<tr>
<td>Desired</td>
<td>32.138</td>
<td>7.791</td>
<td>33.333</td>
<td>4.050</td>
</tr>
<tr>
<td>Available</td>
<td>29.759</td>
<td>5.623</td>
<td>27.250</td>
<td>7.702</td>
</tr>
<tr>
<td>Frequency</td>
<td>28.655</td>
<td>6.014</td>
<td>27.333</td>
<td>7.794</td>
</tr>
<tr>
<td>Usefulness</td>
<td>33.379</td>
<td>7.428</td>
<td>35.000</td>
<td>4.854</td>
</tr>
</tbody>
</table>

correlations between Existential and Religious Well-being ($r = +.6295, p < .001$), as well as between Spiritual Well-being and Existential ($r = +.8741, p < .001$) and Religious ($r = +.9277, p < .001$) Well-being. A one-tailed $t$-test comparing Inspirit scores by group did not prove to be statistically significant (see Table 4).

Given the lack of support for significance between group ratings on social and spiritual measures, these dependent variables were examined by correlational analyses of the continuous variables of time since HIV diagnosis and
Table 4
Means and Standard Deviations of Spirituality Measures by Group

<table>
<thead>
<tr>
<th></th>
<th>HIV Group</th>
<th></th>
<th>AIDS Group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>INSPIRIT</td>
<td>2.893</td>
<td>1.133</td>
<td>2.917</td>
<td>1.018</td>
</tr>
<tr>
<td>EWB</td>
<td>45.071</td>
<td>9.649</td>
<td>36.083</td>
<td>10.430</td>
</tr>
<tr>
<td>RWB</td>
<td>46.750</td>
<td>12.140</td>
<td>44.958</td>
<td>13.977</td>
</tr>
<tr>
<td>SWB</td>
<td>91.821</td>
<td>19.641</td>
<td>81.041</td>
<td>22.221</td>
</tr>
</tbody>
</table>

CD4 cell count to see if more subtle changes in social support and spirituality occurred over the course of HIV disease progression. It was suspected that the Centers for Disease Control definition used to separate the two groups might have been too restrictive a cut-off to gain reliable differences between the two groups as someone in the AIDS group with 198 CD4 cells and someone in the HIV group with 210 CD4 cells may be experiencing more similar circumstances than someone at 50 CD4 cells and 1000 CD4 cells. Many of the correlations proved to be statistically significant, and are discussed in the following sections.
**Correlational Analyses of Stage of HIV Disease and Social Support**

A negative point bi-serial correlation between HIV or AIDS group and availability of someone who expresses confidence in that individual ($r = -0.305, p < .01$) indicates that as one progresses into the symptomatic disease state, perceived availability of others who express confidence in the PWA are significantly diminished. As time since diagnosis with HIV progressed, decreased value was placed on the desirability of: (a) having someone "to talk to" ($r = -0.278, p < .05$), (b) having "someone who expresses confidence in you" ($r = -0.346, p < .05$), (c) having "someone who explains or shows you how they dealt with problems similar to your own" ($r = -0.381, p < .01$), and (d) having "someone who is there for you" ($r = -0.378, p < .01$).

As CD4 count decreased, PWH/PWAs rated increased usefulness of the social support categories which include having someone: (a) who expressed confidence in them ($r = -0.299, p < .05$), (b) who would offer suggestions or advice to assist with problem solving ($r = -0.316, p < .05$), and (c) who would do something to change a situation to decrease stress for the PWA ($r = -0.281, p < .05$). Desire for assistance with changing life situation was also increased as CD4 count decreased ($r = -0.298, p < .05$).
Correlational Analyses of Spirituality and Social Support Subscales

Religious well-being was positively correlated with many subscales of the social support measure. These include availability of someone who would: (a) give suggestions or advice, (b) provide assistance in times of need, (c) be "there" for the PWH/PWA, and (d) do something to help change a stressful situation and frequency of use of all subcategories of the social support scale ($r = +.437$, $p = .001$ for overall frequency of use; see Table 5 for individual correlations). Spiritual Well-being also correlated significantly with the availability and frequency of use subcategories of the social support measure, particularly availability of the emotionally sustaining support subcategory of expressing confidence in the PWH/PWA, all aspects of problem-solving support ($r = +.403$, $p = .003$ for overall problem-solving), indirect personal influence, and environmental action (see Table 5). Positive correlations between availability and frequency of use of particular social support variables and Existential Well-being were also noted (see Table 5).

Positive correlations were found between ratings of availability of "someone who will do something to change" a stressful situation and regular attendance at worship services ($r = .360$, $p < .01$) as well as frequent spiritual practice outside of traditional worship services ($r = .267$,
Frequency of use of "someone who will do something to change" a stressful situation was also positively correlated with attendance at worship services ($r = 0.286, p < 0.05$) and spiritual practice outside traditional services ($r = 0.310, p < 0.05$).

INSPIRIT scores correlated positively with several factors of availability (someone who expresses confidence in the PWH/PWA or offers advice on how to handle a stressor) and frequency (someone to talk to, who understands, expresses confidence in the PWH/PWA, offers explanations or advice, and can assist change in environment) of social supports (see Table 5).

Many of the correlations between social supports and spirituality were significant across all spirituality scales. Those of particular interest are: (a) frequency of use of all four types of social support and (b) availability of someone to express confidence or to advise, or someone who is there that one can turn to in time of need who will do something to change a stressful situation. The majority of scores on all three levels of the SWBS correlate positively with social supports as does the INSPIRIT scale.

**Additional Correlational Analyses**

Living situation, when divided into two categories (i.e.: living alone or living with another adult) was positively correlated with availability of someone to talk to ($r = 0.400, p < 0.01$), but not with other social support
### Table 5

**Significant Correlations Between Social Support Subscales and Spiritual, Religious, and Existential Well-being and INSPIRIT Scores**

<table>
<thead>
<tr>
<th></th>
<th>SWB</th>
<th>RWB</th>
<th>EWB</th>
<th>INSPIRIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>someone to talk to</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>+.142</td>
<td>+.080</td>
<td>+.190</td>
<td>+.146</td>
</tr>
<tr>
<td>A</td>
<td>+.108</td>
<td>+.052</td>
<td>+.158</td>
<td>+.084</td>
</tr>
<tr>
<td>F</td>
<td>+.406**</td>
<td>+.333*</td>
<td>+.411*</td>
<td>+.332*</td>
</tr>
<tr>
<td>U</td>
<td>+.108</td>
<td>+.128</td>
<td>+.058</td>
<td>+.099</td>
</tr>
<tr>
<td>someone who understands</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>+.249</td>
<td>+.064</td>
<td>+.182</td>
<td>+.177</td>
</tr>
<tr>
<td>A</td>
<td>+.231</td>
<td>+.277</td>
<td>+.186</td>
<td>+.156</td>
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<td>F</td>
<td>+.382**</td>
<td>+.013*</td>
<td>+.352**</td>
<td>+.291*</td>
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(Table continues)
variables. The INSPIRIT scale was positively correlated with all three scales of the Spiritual Well-being Scale ($r = +.7018$, $p < .001$); this suggests that they assessed similar concepts, but they are not identical. Neither INSPIRIT nor Spiritual Well-being scores revealed positive correlations with stage of disease progression at months since diagnosis with HIV or CD4 count. Both attendance at traditional worship services and practice of spiritual activities outside of traditional services were positively correlated...
with INSPIRIT scores ($r = .512$ and $r = .644$ respectively with $p < .001$).

**DISCUSSION**

The data collected during this study failed to support the formal hypotheses that persons with symptomatic AIDS would report statistically greater spirituality and less perceived social support than persons with asymptomatic HIV. Correlational analyses of subcategories of the spirituality and social support scales did, however, provide statistically significant findings regarding specific differences in spirituality and social support between persons with asymptomatic HIV and symptomatic AIDS.

**Correlations Between Stage of HIV Disease and Social Support**

Statistically significant correlations were found to exist between individual subscales of the social support scale and stage of HIV at several levels. These findings are consistent with findings in the cancer literature that show as the illness progresses, the person experiencing declining health is less likely to receive or to perceive social support. Particular needs for social support are also suspected to change at different stages in the HIV disease process.

The emotionally sustaining social support category of having someone who expresses confidence in the individual with HIV or AIDS is represented differently at different stages of the disease. In the early months following HIV
diagnosis, there appears to be a stronger desire for someone to express confidence in the person with HIV or AIDS than at later stages in the disease. In addition to the desire to have someone who expresses confidence in them, persons at earlier stages of HIV infection also reported a desire to have someone who explains or shows the individual how they dealt with similar problems and someone who "is there for" them. These results may be explained as persons in the first months following diagnosis desiring emotional support and information regarding what to expect as they begin living with HIV disease. These findings might also be interpreted as the result of the individual at advanced stages of the disease beginning to withdraw from others in the support network or being overwhelmed by the well-intentioned, but unsolicited assistance of others particularly as these supportive behaviors are unable to be reciprocated by the person with HIV due to decline in physical and/or mental abilities.

The negative correlation between HIV/AIDS group membership and perceived availability of someone who expresses confidence in the individual indicates that as one progresses into a symptomatic disease state, the individual experiences real or imagined withdrawal of "faith" from others. Availability of someone who expresses confidence in the PWH/PWA was judged to be more available in the earlier stages of HIV than in the later stages as indicated by
correlations between groups and as time since diagnosis with HIV increased. Primary expression of confidence in the PWA may have come from others in the work, school, or social setting; yet, as the individual begins to experience physical decline, these contacts become increasingly limited due to leaving, reducing, or changing employment or school activities and socializing less outside the home. Further, Hays et al. (1990) report that the ability to reciprocate assistance from others was positively correlated with ratings of psychological well-being. The ability to reciprocate emotionally sustaining or problem-solving assistance may be perceived or expected to diminish as physical and/or mental health deteriorate and is, therefore, not encouraged or sought out by members of the PWH/PWAs social support network. This finding might also support the hypothesis that the social support network of an individual with a chronic or terminal disease may unwittingly convey ambivalent feelings (brought about through a combination of fear/aversion to the disease and social/moral obligation) to the individual (Wortman and Dunkel-Schetter, 1987) which may be perceived as withdrawal of confidence by the PWH/PWA.

As CD4 count diminishes, an increase in the perceived usefulness of (a) faith from others, (b) advice or suggestions to assist problem solving, and (c) someone doing something to change stressful situations is noted. Desire for another to offer assistance to change stressful
situations also increases with CD4 decline. These findings indicate that persons at later stages of the disease would find these types of social support useful if they were available. Some members of the social support network may begin to withdraw attempts at these types of support due to feelings of powerlessness or hopelessness associated with overt physical decline in symptomatic populations. Another reason for diminishing support, particularly in the gay community, may be bereavement overload or burnout which occurs as the social support network is emotionally and physically overwhelmed by increasing numbers of its members becoming ill or dying; this may result in depletion or extinction of the peer support group of the PWH/PWA (Hays et al., 1990).

These statistically significant correlational findings appear to contradict each other in that desire for social support is reportedly diminished while usefulness of this support is rated as increasingly valuable as the disease progresses in time and loss of CD4 cells. It is, however, suspected that self-report of or requests for social support are affected by the respondents belief that the positive value related to social assistance is diminished if one must spend time contemplating unmet needs or is forced to request specific support rather than receiving it spontaneously from a concerned member of the support network.
Correlations Between Spirituality and Social Support

Subscales

Previous research has suggested that as social support declines in persons with terminal illness, religious or spiritual practice begins to take on greater significance (Acklin et al., 1983; Carey, 1974; Gibbs & Achterberg-Lawlis, 1978). The findings in this study do not support this assertion as both measures of spirituality correlated positively with availability and frequency of use of someone to provide social support. However, it is noteworthy that while social support appeared to decline with indicators of disease progression, the spiritual measures did not correlate with disease state. This raises the possibility that either: (a) the role of religious and/or spiritual beliefs may have been weaker at later stages of the disease or (b) that this construct was poorly measured by the scales chosen to examine this phenomena.

Michello (1988) referred to Existential Well-being as the absence of depressed affect. Fehring et al. (1987) found negative correlations between the SWBS and the Beck Depression Inventory and measures of negative affect on the Profile of Mood States. Negative correlations between Spiritual Well-being and loneliness, as well as positive correlations between Spiritual Well-being, self-esteem, and social skills were reported by Paloutzian and Ellison (1982). Since there is evidence that the Spiritual Well-
being Scale overlaps with the measure of depression, it may fail to adequately distinguish spirituality from emotional or affective state. Thus, it may be that the SWBS is simply a "good general indicator of well-being" (Bufford, Paloutzian, & Ellison, 1991, pp. 65-66).

Positive correlations between availability and frequency of use of someone who will do something to help change a stressful situation and regular worship service attendance may be a reflection of provision of social assistance by members of the PWH/PWAs religious community. This finding is encouraging given literature that suggests traditional religious communities have been less supportive of those PWH/PWAs associated with socially stigmatized groups, particularly homosexuals (Kayal, 1985; Tibesar, 1986). It is a positive indication that traditional religious faiths are becoming more accepting of alternative life-styles. Many churches are inviting those who have separated from the church in order to reduce cognitive dissonance between religious teachings and lifestyle to return to this more enlightened and accepting environment (Leadership Conference of Christian Churches of the Central Coast of California, 1988). Additionally, there are places of worship that have developed to meet the needs of the homosexual community, such as Metropolitan Community Church whose membership is predominantly made-up of persons who are gay and lesbian.
The positive correlations found between availability and frequency of use of "someone who will do something to change" a stressful situation with spiritual practice outside of traditional worship services may be explained in a social or spiritual context. Since information was not gathered on the specific nature of the spiritual practice outside of traditional worship, it might be hypothesized that bible study or other spiritual group activities might be organized outside the church and that members of these groups provide additional levels of environmental assistance to one another. Viewing this data from a spiritual context, several respondents wrote comments in the margins of the standardized social support questionnaire that indicated a reliance on God or a Higher Power to provide assistance with stressful situations; this leads one to wonder how many others might have interpreted these items in a similar manner without making additional comment. In light of this evidence, it might be hypothesized that as the social support network diminishes, the PWH/PWA begins to rely increasingly on prayer and meditation to produce some type of divine intervention which may assist them with changing stressful life circumstances. This hypothesis is further supported by positive correlations between SWBS and INSPIRIT scores and availability and frequency of use of all types of social support. Since the INSPIRIT is a measure of more concrete spiritual experiences such as personal communion
with a higher spiritual force (e.g.: experience of the presence of God, of great spiritual figures, or of guiding angels), respondents may perceive these types of social support or assistance to come from spiritual forces.

Participant self-selection. Due to the limited response to this research project and apparent homogeneity of respondents, response bias must be explored as a possible confounding variable in data collection. Possible participants had several occasions during which they could drop-out of the participant pool. Initially, a possible participant could refuse to accept a research packet. After receipt of the research packet, many participants chose not to complete the questionnaires or not to return the packet to the researcher. Denial has been suggested as a temporary defense mechanism, particularly in asymptomatic populations (Hays et al., 1990; Warner-Robbins & Christiana, 1989). Participation in this project might have threatened the denial mechanisms of possible participants who unwilling or ill-prepared to explore feelings or spiritual issues surrounding their HIV status. Other reasons reported by agency staff for participant drop-out generally involved the survey being too lengthy to consider or completion becoming too time consuming; problems with English literacy also resulted in loss of possible participants.

Research with PWAs indicates that they are at high risk for psychological symptomatology which manifests in
dysphoric mood, anxiety, hopelessness, helplessness, and suicidal crisis (Hays et al., 1990; Tross & Hirsch, 1988). Divergent hypotheses have been postulated in the literature to explain this finding: (a) lack of social support, particularly in times of stress, may precipitate depression in an individual or (b) depressive affect may negatively influence the individual's perception of availability of support or (c) the support network may withdraw over time as the depressive behaviors of the individual continues (Heitzmann & Kaplan, 1988; Namir et al., 1989; Zich & Temoshok, 1990). Depressive symptoms in possible participants could have resulted in a failure to complete the questionnaire due to diminished ability to concentrate, fatigue or loss of energy, or decreased interest in activities. Studies have found that those who reported satisfaction with their social support networks exhibited less hopelessness and depression and more active-positive coping strategies than those who were reportedly dissatisfied with social support (Namir et al., 1989; Zich & Temoshok, 1987). Persons exhibiting these active-behavioral coping strategies evidenced lower levels of mood disturbance and greater self-esteem (Namir et al., 1987).

Since both groups revealed similar response styles, it might be suggested that those with the "survivor's attitude" or "fighting spirit" respond to any change or progression in their HIV status with positive action and activism which
might include participation in research projects. It has been suggested that persons with a "survivor’s attitude" or "fighting spirit" are more likely to take control of their lives and management of their disease through active participation (Carson et al., 1990; Derogatis, Abeloff, & Melisaratos, 1979; Greer, Morris, & Pettingale, 1979; Pettingale, 1984) in: (a) spiritual activities, (b) research or forum presentations on HIV/AIDS related topics, (c) political and social activities related to HIV/AIDS (Carson et al., 1990; Moulton et al., 1990; Namir et al., 1987).

Low response rate by women may be secondary to decreased energy and/or time-constraints due to traditional care-taking roles, parental obligations, and household duties (Ports, 1988) in addition to work/career commitments, medical complications, and daily stressors. In addition, since women are generally involved in more intimate interpersonal relationships premorbidly (Flaherty & Richman, 1989) and may be unable to access or attend HIV/AIDS social support groups outside the traditional gay male community, they may rely on preexisting supports from family and intimate friends and be inaccessible to research projects seeking participants through formal community support groups.

It is suspected that the percentage of referrals made by questionnaires allotted was greater in some agencies than
others. In some instances, it appears those distributing the surveys chose to approach only certain eligible persons receiving services rather than successive eligible individuals presenting for services.

Summary

Despite non-significant findings related to the formal hypotheses regarding differences in social support and spirituality between persons with asymptomatic HIV and symptomatic AIDS, correlational analyses did support that differences do exist at different stages as one progresses from asymptomatic HIV to symptomatic AIDS.

Correlational analyses between length of time since diagnosis or CD4 count and social support categories revealed that as one progresses toward AIDS, the perception of social support availability diminishes while the perceived usefulness of such support (if it were available) gains importance. Spiritual practice and belief also correlated positively with social support, but did not correlate significantly with measures of disease progression. This differs from previous research which suggested social support and spiritual and/or religious practices as effective buffers to assist the individual in coping with life-threatening circumstances. It is suspected that the non-significant findings regarding this issue may be due, in part, to confounding of the measurement of
spiritual well-being with items that appear to be face valid measures of well being and depression.

Future Directions

Future research in this area might draw sample populations from a broader recruitment base which should insure representative samples of women, heterosexual males, IV drug abusers, persons of color, and hemophiliacs in addition to homosexual males.

Mays and Jackson (1991) suggest that "segments of the Black population" at risk for HIV/AIDS may include homeless or transient persons, those in shelters or Board and Care facilities, or prisoners in local jails or detention centers and state prisons. These same conditions are believed to apply to IV drug abusers as well. The ALIVE study protocol (Vlahov, Anthony, Munoz, Margolick, Nelson, Celentano, Solomon, & Polk, 1991) is a model for overcoming such environmental and social barriers to representative sampling. The recruitment phase of the ALIVE study involved area drug abuse treatment programs, the Division of Parole and Probation, City Health Department's sexually transmitted disease clinics, hospital emergency rooms, homeless shelters, local housing projects, and Street Outreach AIDS Prevention project and offered financial compensation for initial participation and follow-up visits. Other reasons for difficulty in recruitment of minority members of the gay population may be their minimal contact with the
"traditional white gay organizations" (Ostrow et al., 1991) through which many researchers recruit participants.

Due to historical factors in the presentation of the HIV/AIDS to the general public, gay communities were the first to mobilize support and advocacy for PWH/PWAs. The gay community remains the strongest and most prominent resource for persons with HIV and AIDS. Women and straight males often report feeling uncomfortable participating in primarily gay male social support groups as the issues facing these participants are different. Persons who acquired the virus through blood transfusion secondary to hemophilia appear to receive the majority of their HIV related services from the facilities which were initially providing medical and social services for hemophilia, but this population is under-represented in the literature. Examination of specific characteristics of the social support networks of participants from different racial and cultural backgrounds might also yield valuable information for enhancement of social support provision in persons with HIV/AIDS who exist outside the traditional gay community.

Longitudinal studies of persons as they progress from high-risk behavior to HIV+ to AIDS might also make the process of changes in social support and spiritual practices/beliefs more clear. Once these processes are better understood, programs may be developed to enhance
existing networks or provide services that are not available through traditional or pre-existing community resources.
Letter to Participants

Attached you will find a questionnaire about your beliefs and experiences living with HIV or AIDS. This questionnaire makes up part of a research project designed to examine how environment and beliefs may affect overall health in persons living with HIV and AIDS. Completion of the attached packet is VOLUNTARY and should take approximately one hour of your time.

There is no need to place your name on any of these materials unless you agree to participate in the follow-up survey explained on the last page of this packet. All surveys are completely ANONYMOUS.

Your completion of the attached questionnaire would be greatly appreciated. If you decide to participate, please complete all questions to the best of you ability, seal them in the attached envelope and return them to the agency or individual who gave them to you OR drop the postage-paid envelope in a mailbox at your convenience.

Thank you for taking the time to review these materials.

__________________________
Tamara L. Elkins, M.A.
Research Coordinator

If you have any questions or concerns regarding this research, please contact me at: University of North Texas, Department of Psychology, P.O. Box 13587, Denton, TX 76201 or phone (817) 565-2671.

If you would like to speak to someone other than the researcher, please contact Dr. Jerry McGill of Texas College of Osteopathic Medicine, Department of Psychiatry at (817) 735-2334.
Demographics Questionnaire

Age: ______

Please check the item that best applies to you.

Sex: ______ Male ______ Female

Ethnicity: ____ African American ____ Asian ____
Caucasian ____ Hispanic
____ Other (please specify) ______________________

Education: ____ Some High School ____ High School Graduate
____ Some College ____ College Graduate
____ Graduate Degree

Occupation/Job Title: ______________________________

Current Employment Status: ____ Full Time ____ Part Time
____ Self-Employed ____ Homemaker ____ Unemployed
____ Student

Have you been forced to change job status or quit jobs due to HIV? YES NO

If YES, briefly explain circumstances:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Are you receiving disability insurance?  YES  NO  

Please indicate your current annual income (include disability):

___ below $10,000  
___ $10,000 to $20,000  
___ $20,000 to $30,000  
___ $30,000 to $40,000  
___ $40,000 to $50,000  
___ Over $50,000

Please check all that apply to your current living situation:

___ Alone  ___ With Spouse/Lover  ___ With Parent(s)  
___ With Children  ___ With Friend/Roommate  
___ With Other Family (Siblings, Cousins, etc.)  
___ In Hospital  ___ Group Home for PWAs  
___ Homeless

What is the status of your relationship with a significant other?

___ Single  
___ In a committed relationship with a person of the same sex  
___ In a committed relationship with a person of the opposite sex  
___ Separated  
___ Divorced  
___ Widowed
Have your sexual partners since 1978 consisted of:

___ Men Only  ___ Women Only  ___ Both Sexes
___ No Partners

Do you consider yourself primarily:

___ Heterosexual  ___ Homosexual  ___ Bisexual

What was the date (month/year) you were informed of your diagnosis of:  HIV _____  ARC _____  AIDS _____

If you know it, please indicate your last white blood cell count:  WBC= ________________

If you can, please indicate by marking an "X" next to any possible route of your virus transmission (mark more than one if they could apply).

___ I.V. drug use
___ anal intercourse
___ oral sex
___ vaginal intercourse with I.V. drug user
___ vaginal intercourse with bisexual male
___ vaginal intercourse with heterosexual male or female
___ transfusion due to hemophilia
___ transfusion for medical reason other than hemophilia
___ needle stick in medical setting
___ unsure of route of transmission
Please indicate your religious affiliation by placing an "X" next to the religion you most identify with or practice regularly:

___ Agnostic
___ Baptist
___ Christian Scientist
___ Church of Christ
___ Church of God
___ Hindu
___ Jehovah’s Witness
___ Judaism
___ Methodist
___ Pentecostal (Assembly of God)
___ Roman Catholic
___ Seventh Day Adventist
___ Other (please name)

Do you believe in a higher power or God?  YES  NO
Please indicate how often you attend regular worship services:

___ Never  ____ 1-5 times per year  ____ 6-10 times per year  ____ 1-3 times per month  ____ weekly  ____ daily  ____ other (please describe) ________________________________

Please indicate how often you pray, meditate, or read or contemplate spiritual materials outside of traditional worship services:

___ Never  ____ Only in times of crisis or stress  ____ monthly  ____ weekly  ____ daily  ____ other (please describe) ________________________________

Has your diagnosis helped you to grow in any way (e.g.: spiritually, in relationships or behavior toward others, etc.)?  
___ YES  ____ NO

If YES, please explain: ____________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
Can you find any meaning or purpose for your contracting this disease (e.g.: helped you make important life decisions, made you realize importance of each day, made you slow down)?

YES  NO

If YES, please explain: ________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________
APPENDIX C

SOCIAL SUPPORT SCALE
Social Support Scale

Please read the following statements (and the examples given in quotes) and then rate them using the scale indicated before each group of statements.

For items 1-8, please use the following rating scale to complete the statements:

1=EXTREMELY UNDESIRABLE
2=SOMewhat UNDESIRABLE
3=NEUTRAL
4=SOMewhat DESIRABLE
5=EXTREMELY DESIRABLE

1. Having someone to talk to ("He or she will talk things over with me") is __________ to me. ..........1 2 3 4 5

2. Having someone who understands my problems or feelings ("He or she knows what I’m going through") is __________ to me. ..........1 2 3 4 5

3. Having someone who expresses confidence in me ("He or she seems to have faith in me") is __________ to me. ..........1 2 3 4 5

4. Having someone who gives me suggestions or advice about how to solve a problem ("He or she advised me to try something different") is __________ to me. ..........1 2 3 4 5

5. Having someone who explains or shows me how they dealt with problems similar to mine ("Just seeing how he or she handles situations helps me know what to do") is __________ to me. ..........1 2 3 4 5

6. Having someone who I can turn to when I need to borrow something like a household object or money or need help with an errand ("He or she came over and helped me move so I wouldn’t have to do it by myself") is __________ to me. ..........1 2 3 4 5
1=EXTREMELY UNDESIRABLE
2=SOMewhat UNDESIrABLE
3=NEUTRAL
4=SOMewhat DESIRABLE
5=EXTREMELY DESIRABLE

7. Having someone who is there for me
   ("I can always count on him or her")
   is ______ to me.............................1 2 3 4 5

8. Having someone who will do something to
   change my situation so I’ll be under less
   stress ("He or she helped by talking to
   the landlord and convincing him to wait
   for the money for a while") is ______
   to me........................................1 2 3 4 5

For items 9-16, please use the following rating scale to
   complete the statements:
   1=ALWAYS
   2=OFTEN
   3=SOMETIMES
   4=RARELY
   5=NEVER

9. I ______  have someone to talk to
   ("He or she will talk things over
   with me").................................1 2 3 4 5

10. I ______ have someone who understands my
    problems or feelings ("He or she knows what
    I’m going through")......................1 2 3 4 5

11. I ______ have someone who expresses
    confidence in me ("He or she seems to have
    faith in me")...........................1 2 3 4 5

12. I ______ have someone who gives me
    suggestions or advice about how to solve a
    problem ("He or she advised me to try
    something different")....................1 2 3 4 5

13. I ______ have someone who explains or shows
    me how they dealt with problems similar
    to my own ("Just seeing how he or she handles
    situations helps me know what to do")....1 2 3 4 5
14. I _______ have someone who I can turn to when I need to borrow something like a household object or money or need help with an errand ("He or she came over and helped me move so I wouldn’t have to do it by myself") ..........................1 2 3 4 5

15. I _______ have someone who is there for me ("I can always count on him or her") ........1 2 3 4 5

16. I _______ have someone who will do something to change my situation so I’ll be under less stress ("He or she helped by talking to the landlord and convincing him to wait for the money for a while") ...............1 2 3 4 5

For items 17-24, please use the following rating scale to complete the statements:

1=CONSTANTLY
2=OFTEN
3=SOMETIMES
4=RARELY
5=NEVER

17. I _______ use or access someone who will talk things over with me ("He or she will talk things over with me") .........................1 2 3 4 5

18. I _______ use or access someone who understands my problems or feelings ("He or she knows what I’m going through") ........1 2 3 4 5

19. I _______ use or access someone who expresses confidence in me ("He or she seems to have faith in me") .........................1 2 3 4 5

20. I _______ use or access someone who gives me suggestions or advice about how to solve a problem ("He or she advised me to try something different") .........................1 2 3 4 5
21. I ______ use or access someone who explains or shows me how they dealt with problems similar to my own ("Just seeing how he or she handles situations helps me know what to do") 1 2 3 4 5

22. I ______ use or access someone who I can turn to when I need to borrow something like a household object or money or need help with an errand ("He or she came over and helped me move so I wouldn’t have to do it by myself") 1 2 3 4 5

23. I ______ use or access someone who is there for me ("I can always count on him or her") 1 2 3 4 5

24. I ______ use or access someone who will do something to change my situation so I'll be under less stress ("He or she helped by talking to the landlord and convincing him to wait for the money for a while") 1 2 3 4 5

For items 25-32, please use the following rating scale to complete the statements:

1=VERY HARMFUL
2=SOMewhat HARMFUL
3=HAS NO IMPACT/DOESN'T OCCUR
4=SOMewhat HELPFUL
5=VERY HELPFUL

25. I find it ______ to have someone to talk to ("He or she will talk things over with me") 1 2 3 4 5

26. I find it ______ to have someone who understands my problems or feelings ("He or she knows what I'm going through") 1 2 3 4 5
1=VERY HARMFUL
2=SOMewhat HARMFUL
3=HAS NO IMPACT/DOESN'T OCCUR
4=SOMewhat HELPFUL
5=VERY HELPFUL

27. I find it ______ to have someone who expresses confidence in me ("He or she seems to have faith in me") ...............1 2 3 4 5

28. I find it ______ to have someone who gives me suggestions or advice about how to solve a problem ("He or she advised me to try something different") ..................1 2 3 4 5

29. I find it ______ to have someone who explains or shows me how they dealt with problems similar to my own ("Just seeing how he or she handles situations helps me know what to do") ...............1 2 3 4 5

30. I find it ______ to have someone who I can turn to when I need to borrow something like a household object or money or need help with an errand ("He or she came over and helped me move so I wouldn't have to do it by myself") ..................1 2 3 4 5

31. I find it ______ to have someone who is there for me ("I can always count on him or her") ..................1 2 3 4 5

32. I find it ______ to have someone who will do something to change my situation so I'll be under less stress ("He or she helped by talking to the landlord and convincing him to wait for the money for a while") .......1 2 3 4 5
APPENDIX D

REQUEST FOR PARTICIPATION IN FOLLOW-UP STUDY
Request for Participation in Follow-Up

Thank you for completing the survey. Please take an additional moment to read the following:

We could learn a great deal more about these issues if we could re-survey participants in this study at 6, 12, and 18 month intervals in order to determine how social support systems and spiritual beliefs might change over time. If you would feel comfortable in participating in a follow-up study, please provide your name and mailing address below. Your name and matched code-number will be kept separately in a locked file cabinet in the researcher’s office. This list will be destroyed at the end of the research project. Your name will not be placed on any survey material at any time.

Your Name: ________________________________________________
Mailing Address: ____________________________________________

Thank you for considering this option.

If you would like more time to consider further participation, please remove this page and keep it with you until you decide. If, at a later time, you decide to participate, please mail this completed page to: Tamara L. Elkins, M.A. c/o University of North Texas Department of Psychology P.O. Box 13587 Denton, TX 76201.

If you do NOT wish to participate further, THANK YOU for your time.

Please return this packet, in the envelope provided, to your counselor or through the mail. THANK YOU.
REFERENCES


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