Chapter 1

Introduction
Chapter 1
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This study seeks to standardize two instruments, namely, Spiritual Distress Scale and Spiritual Coping Scale; and to examine the influence of gender, stages of HIV/AIDS and the interaction between them on spiritual distress and spiritual coping among people living with HIV/AIDS.

1.1 Background of the study

HIV/AIDS emerged as a major health problem, the epidemic has serious and devastating effects on human development. It can lead to spiritual distress that in turn affects the coping process. This infection has become the eighth leading cause of death. It is estimated that there is one HIV infection related death in every fifteen minute, one HIV diagnose in every nine minute and someone infected with HIV in every thirteen minute (McEnany, Huges, & Lee, 1995).

Spiritual distress (Hay, 1989; Smucker, 1996) and spiritual crisis occur when individuals are unable to find sources of meaning, hope, love, peace, comfort, strength and connection in life or when conflict occurs between their beliefs and what is happening in their life. This distress can have a detrimental effect on physical and mental health. HIV can often trigger spiritual distress in patients.

People with HIV/AIDS incorporate spirituality as a way to cope, to help reframe their lives, and to bring a sense of meaning and purpose to their lives in the face of an often devastating situation (Hall, 1998; Siegel & Schrimshaw, 2002). In people with HIV/AIDS, higher levels of spirituality have been associated with improvements in life satisfaction, functional health status, health-related quality of life (HRQOL), and overall well-being, even when controlling for other salient factors (e.g., age, HIV symptoms) (Pargament, McCarthy, & Shah, 2004; Somlai & Heckman, 2000; Tsevat, Sherman, & McElwee, 1999; Tuck, McCain, & Elswick, 2001). Some studies have, however, shown that negative manifestations of spirituality may be associated with poorer health outcomes. Spiritual distress might have a potentially harmful effect on patients’ prognosis and quality of life (Astrow, Wexler, Texeira, He, & Sulmasy, 2007; Grant, Murray, Kendall, Boyd, Tilley, & Ryan, 2004; Hills, Paice, Cameron, & Shott, 2005; Monod, Rochat, Martin, & Bula, 2007).
Chapter 1: Introduction

Research indicates that people reflect on their spirituality after being diagnosed with HIV/AIDS by incorporating their understanding of God and previous religious/spiritual experiences as part of their coping repertoire (Jacobson, Luckhaupt, Delaney, & Tsevat, 2006; Tarakeshwar, Swank, Pargament, & Mahoney, 2006). Spirituality uniquely predicts health and well-being outcomes in those with HIV/AIDS such as improvements in life satisfaction, functional health status, and health-related quality of life after controlling for factors such as age and HIV symptoms (Pargament, McCarthy, Shah, Ano, Tarakeshwar, & Wachholtz, 2004). Higher levels of spirituality have been associated with less pain and increased energy (Ramer, Johnson, Chan, & Barrett, 2006), less psychological distress (Simoni, Martone, & Kerwin, 2002), less depression (Coleman, 2004; Simoni & Ortiz, 2003), better mental well-being (Braxton, Lang, Sales, Wingood, & DiClemente, 2007; Coleman, 2004), better cognitive and social functioning, and fewer HIV symptoms (Coleman, 2004).

Numerous studies in the social science field have explored HIV coping. Studies have revealed that people living with HIV utilise a variety of coping strategies, such as denial, distraction, social support, religion, acceptance and direct action (Burchardt, 2010; Deichert, Fekete, Boarts, Druley, & Delahanty, 2008; Hodge & Roby, 2010; Pence, Thielman, Whetten, Ostermann, Kumar, & Mugavero, 2008; Stein & Rotheram-Borus, 2004). People living with HIV/AIDS confront uncertainties about their future personal health and social adjustments. Many individuals with HIV live more than a decade with the threat of increasing disability, loss of employment, stigmatization of self and family, and premature death. However, many HIV infected individuals cope effectively with their condition and continue to lead productive, meaningful lives. Unfortunately, many others have difficulty in managing the stresses associated with their condition. Hence, buffering distress and adjusting to life stressors are highly important for HIV positive populations because that might then enable treatment adherence, better quality of life and better psychosocial adjustment. The ability to cope successfully with a chronic illness, such as HIV is influenced by a number of social, psychological and spiritual factors.
1.2 Statement of the problem

Spiritual distress is a state in which beliefs or value systems are disturbed or are at risk of being disturbed. Disturbing events such as illnesses, multiple losses, and facing death require that the individual rely on his or her spiritual beliefs and practices to maintain the strength and courage to continue living. When people living with HIV/AIDS begin to questions “Why me?” and “What is the meaning of this event?” they are experiencing a conflict between their beliefs and the reality of the situation, and spiritual distress results. The individual’s beliefs and values no longer provide a framework for understanding life and one’s purpose and meaning in life.

Spirituality provides a source of hope. Spiritual coping may assist HIV/AIDS people in providing a sense of control in understanding their problem and interpreting events or experiences. HIV individuals with spiritual distress can reduce the stressful reactions by adopting the spiritual coping strategies.

The experience of being diagnose with HIV/AIDS is extremely stressful and the reaction of others to the patient’s diagnosis constitute a significant concern. The specific fears of persons with HIV/AIDS include pain, death, spiritual distress, child’s education and future, fear of loss of job and being rejected by family, friend and society due to ill health (or when HIV status is revealed) and may indicate the exposure of their promiscuous sexual behaviour or unsafe sexual activity. The uncertainty of the outcome of the infection can lead to spiritual distress.

The present study has been conducted on the ground of need for studying spiritual distress and spiritual coping among males and females living with different stages of HIV/AIDS. How the problem of spiritual distress is confronted and how the patients of HIV/AIDS can be helped to find new ways of spiritual coping are the major concerns of the present study. In modern medicine, all the attention is focused on the removal of physical pain and symptoms through medications and procedures used to relieve them, while the real pain that spiritual distress can cause is neglected and not addressed. So, even though spiritual distress is very uncomfortable and potentially dangerous to the patient’s health, whether or not a physical disease is already present, it is also an opportunity to grow, evolve, and transcend one’s limitations to a new sense of self and one’s relationship to the world. In the process of identifying the signs and symptoms of the spiritual distress, and ways of spiritual coping, it is possible for the investigator to develop insight, creativity, a sense of hope, and a plan of action among people living with different stages of HIV/AIDS.
Spiritual distress may have negative influence on health outcome of HIV in the population but the human beings have the potential to develop their life purposes which can be affected by the experience of HIV, where spiritual coping process emerge as a human expression in search of balance or improving quality of life perspective. The present research is undertaken to study systematically to examine spiritual distress and spiritual coping among people living with different stages of HIV/AIDS.

Spirituality has been found to play an important role in the lives of people and it has also been identified as a potentially powerful coping resource for HIV/AIDS population. Therefore, the present investigator felt the need to standardize two goal-specific measures, namely, spiritual distress scale and spiritual coping scale. Exploring spiritual distress of HIV/AIDS patients can empower to the investigator to evaluate their lives and suggest them certain ways of spiritual coping.

The following sections will present the detailed account on HIV/AIDS, spiritual distress and coping strategies.

1.3 Human Immunodeficiency Virus (HIV) is an illness that causes a considerable amount of stress in those living with the condition (Ironson & Kremer, 2010). It is estimated that 33.4 million people suffer from HIV and Acquired Immunodeficiency Syndrome (AIDS) worldwide (UNAIDS Epidemic Update, 2009). This particular illness causes considerable distress because people with HIV (PWH) face social stigma, fear of rejection from friends and family, and substantial amounts of uncertainty (Seigel & Lekas, 2002). PWH, like all who live with a chronic condition, also carry the responsibility of following treatment and medication regimens along with making and maintaining necessary lifestyle changes.

Living with HIV is associated with high levels of stress, including disclosure concerns (Rodkjaer, Sodermann, Ostergaard, & Lomborg, 2011), HIV-related neurocognitive impairment (Antinori, Arendt, Becker, Brew, Byrd, & Cherner, 2007; Heaton, Grant, Butters, White, Kirson, & Atkinson, 1995; Reger, Welsh, Razani, Martin, & Boone, 2002), and stigmatization (Chapman, 2002; Rutledge & Abell, 2005).

HIV/AIDS is accompanied by multiple stressors, which include the management of treatment regimens that are complex. HIV/AIDS affects the society as a source of discrimination, economic impairment, as well as illness (UNAIDS, 2006).
People believe that HIV/AIDS can be transmitted by non-sexual contact (Myth Busters, 2016). This disease is facing many controversies inclusive of catholic church’s decision of not supporting condom use as a preventive measure to HIV/AIDS (McCullom, 2013). Due to its long term effects this disease has attracted many international medical and political agencies for large scale funding (Harden, 2012).

1.3.1 Origin, Meaning and Definitions of HIV/AIDS

It is ongoing debate that, from where this disease originated, and the debate still goes on. In this debate, there are two famous arguments, for instance one group of scholars argue that this disease spread by jumping of monkeys over mankind in Sub-Saharan African community. For this explanation African scholars possesses strong objection. Similarly, other group of expert say that it is spread due to homosexual activities in developed world, but Western scholars places a strong objection on it. In this debate, four theories are proposed regarding the origin of HIV/AIDS.

HIV is referred as “Modern pandemic” which is a fatal disease caused by retrovirus known as ‘Human Immunodeficiency Virus’. These break down body’s immune system and are likely to develop life threatening opportunistic infections, neurological disorder and unusual malignancies (Park, 2009).

HIV breaks down the immune system — our body’s protection against disease. HIV causes people to become sick with infections that normally would not affect them. HIV is a retrovirus that specifically attacks the CD4 cells (also known as T-helper cells) of the human body, which are defensive cells that form part of the human immune system. CD4 cells defend the human body against harmful elements such as bacteria, viruses and certain cancer cells and produce and aid in the development of substances that further protect the body. By attacking CD4 cells, HIV causes the number of CD4 cells to decrease, thereby leading to a decline in the immune system’s ability to adequately protect the body. AIDS is caused by HIV and develops in the advanced stages of HIV-infection (UNAIDS, 2008).

AIDS is stands for acquired immunodeficiency syndrome. It is the most advanced stage of HIV disease. AIDS is defined as a “syndrome of opportunistic infections and certain cancers” which is acquired as the individual’s immune system
becomes progressively less able to protect itself due to the HIV-infection (Van Dyk, 2008). These opportunistic infections and cancers become increasingly more time progresses and will ultimately lead to death. From the time of becoming infected with HIV, it can take a number of years before a person develops AIDS, depending on the specific HIV strain they have as well as their general health status (Van Dyk, 2008). HIV-infection is treated with antiretroviral (ARV) medication, which can help to delay AIDS disease progression by decreasing the HIV-positive person’s viral load (UNAIDS, 2008).

1.3.2 Global, Regional and India Estimates of HIV/AIDS

According to the joint estimates made by UNAIDS and WHO, reported that 65 million people have been infected with HIV/ AIDS and more than 25 million people have died due to HIV/ AIDS since it was first recognized in 1981. According to the estimates made by UNAIDS and WHO 39.5 million people are living with HIV, ninety-four per cent people are adult and remaining six percent are children below 15 years, 2.1 million children under 15 were living with HIV. Among adult population, 52.41 percent are males and 47.58 percent are females. Among the newly infected people, 88 percent are adults, and among the total deaths 90 percent are adults. It is only the adult population which is targeted by this disease, which is demographically and economically most productive. According to the World Health Organization (WHO), it is estimated that there are approximately 3.5 crores people infected with HIV/AIDS universally as of December 2013 (UNAIDS Gap Report, 2014). In the year 2014, it was estimated that 1.2 million deaths had occurred from the 36.9 million population having HIV/AIDS (World Health Organization (WHO), 2015). Further, mostly infected with HIV/AIDS were living in Sub-Saharan Africa (World Health Organization, 2015), it is estimated that from its discovery till 2014, HIV caused 39 million deaths globally (Centers for Disease Control and Prevention, 2015).

HIV prevalence in India varies geographically. India is the third largest country in the world on account of HIV/AIDS population with 2.1 million Indians accounting for about four out of 10 people infected with the deadly virus in the Asia—Pacific region. In 2011, there are 21 lakhs people living with HIV/AIDS in India as reported by UN Report. Children below the age of 15 years consist of 7% (1.45 lakhs) of all infections, while 86% are in the age group of 15-49 years. Of all HIV infections, 39% (8.16 lakhs) are among women. It has been seen a decline in HIV/AIDS population in
India as it was 23.2 lakhs in 2006 and 21 lakhs in 2011. The four high prevalence states of South India (Andhra Pradesh – 500,000, Maharashtra – 420,000, Karnataka – 250,000, Tamil Nadu – 150,000) account for 55% of all HIV infections in the country. West Bengal, Gujarat, Bihar and Uttar Pradesh are estimated to have more than 100,000 PLWHA each and together account for another 22% of HIV infections in India. India is estimated to have around 1.16 lakhs annual new HIV infections among adults and around 14,500 new HIV infections among children in 2011. Of the 1.16 lakhs, estimated new infections in 2011 are among adults. The six high prevalence states account for only 31% of new infections, while the ten low prevalence states of Odisha, Jharkhand, Bihar, Uttar Pradesh, West Bengal, Gujarat, Chhattisgarh, Rajasthan, Punjab & Uttarakhand together account for 57% of new infections. The greater vulnerabilities in these states are being given higher focus in the AIDS control programme.

India has the third highest number of estimated people living with HIV/AIDS (PLHIV) in the world. At the end of 2013, more than 700,000 people were on antiretroviral therapy, the second largest number of people on treatment in any single country (NACO, 2013).
1.3.3 Signs and Symptoms of HIV

Usually people takes more than 10 years in developing symptoms of HIV but some people develop symptoms faster that is shortly after being infected. There are 4 stages of HIV disease. The first and most important HIV symptoms may include swollen glands in the throat, armpit, or groin, and the second early HIV symptoms include slight fever, headaches, fatigue, and muscle aches. These symptoms may last for only few weeks. Then there are usually no HIV symptoms for many years. That is why it can be hard to know if you have HIV.

AIDS is the last stage of HIV/AIDS and its symptom appear in the most advanced stage of HIV disease. In addition to a badly damaged immune system, a person with AIDS may also have thrush — a thick, whitish coating of the tongue or mouth that is caused by a yeast infection and sometimes accompanied by a sore throat, severe or recurring vaginal yeast infections, chronic pelvic inflammatory disease, severe and frequent infections, periods of extreme and unexplained tiredness that may be combined with headaches, light-headedness, and/or dizziness, quick loss of more than 10 pounds of weight that is not due to increased physical exercise or dieting, bruising more easily than normal, long periods of frequent diarrhoea, frequent fevers and/or night sweats, swelling or hardening of glands located in the throat, armpit, or groin, periods of persistent, deep, dry coughing, increasing shortness of breath, the appearance of discoloured or purplish growths on the skin or inside the mouth, unexplained bleeding from growths on the skin, from the mouth, nose, anus, or vagina, or from any opening in the body, frequent or unusual skin rashes severe numbness or pain in the hands or feet, the loss of muscle control and reflex, paralysis, or loss of muscular strength, and confusion, personality change, or decreased mental abilities.
There are three main stages of HIV infection: acute infection, clinical latency and AIDS (Department of Health & Human Services, 2010).

1.3.3.1 Acute infection:

Main symptoms of Acute HIV infection

Systemic:
- Fever
- Weight loss

Pharyngitis

Mouth:
- Sores
- Thrush

Esophagus:
- Sores

Muscles:
- Myalgia

Liver and spleen:
- Enlargement

Central:
- Malaise
- Headache
- Neuropathy

Lymph nodes:
- Lymphadenopathy

Skin:
- Rash

Gastrointestinal:
- Nausea
- Vomiting
Main symptoms of acute HIV infection

The initial period following the contraction of HIV is called acute HIV, primary HIV or acute retroviral syndrome (Mandell, Bennett, & Dolan, 2010; World Health Organization, 2007). Many individuals develop an influenza-like illness or a mononucleosis-like illness 2–4 weeks post exposure while others have no significant symptoms (Tarrytown & Cavendish, 2008; Mandell, Bennett, & Dolan, 2010). Symptoms occur in 40–90% of cases and most commonly include fever, large tender lymph nodes, throat inflammation, a rash, headache, and/or sores of the mouth and genitals (World Health Organization, 2007; Mandell, Bennett, & Dolan, 2010). The rash, which occurs in 20–50% of cases, presents itself on the trunk and is maculopapular, classically (Vogel, Schwarze-Zander, Wasmuth, Spengler, Sauerbruch, & Rockstroh, 2010). Some people also develop opportunistic infections at this stage (World Health Organization, 2007). Gastrointestinal symptoms such as nausea, vomiting or diarrhoea may occur, as may neurological symptoms of peripheral neuropathy or Guillain-Barre syndrome (Mandell, Bennett, & Dolan, 2010). The duration of the symptoms varies, but is usually one or two weeks (Mandell, Bennett, & Dolan, 2010).

Due to their nonspecific character, these symptoms are not often recognized as signs of HIV infection. Even cases that do get seen by a family doctor or a hospital are often misdiagnosed as one of the many common infectious diseases with overlapping symptoms. Thus, it is recommended that HIV be considered in people presenting an unexplained fever who may have risk factors for the infection (Mandell, Bennett, & Dolan, 2010).

1.3.3.2 Clinical latency

The initial symptoms are followed by a stage called clinical latency, asymptomatic HIV, or chronic HIV (Department of Health & Human Services, 2010) Without treatment, this second stage of the natural history of HIV infection can last from about three years (Evian, 2006) to over 20 years (Hicks, Reeders, & Goodman, 2001) (on average, about eight years) (Elliott, Casey, Lambert, & Sandoe, 2012). While typically there are few or no symptoms at first, near the end of this stage many people experience fever, weight loss, gastrointestinal problems and muscle pains (Department of Health & Human Services, 2010). Between 50 and 70% of people also develop persistent generalized lymphadenopathy, characterized by unexplained,
non-painful enlargement of more than one group of lymph nodes (other than in the groin) for over three to six months (Mandell, Bennett, & Dolan, 2010).

Although most HIV-1 infected individuals have a detectable viral load and in the absence of treatment will eventually progress to AIDS, a small proportion (about 5%) retain high levels of CD4+ T cells (T helper cells) without antiretroviral therapy for more than 5 years (Blankson, 2010; Mandell, Bennett, & Dolan, 2010). These individuals are classified as HIV controllers or long-term nonprogressors (LTNP) (Blankson, 2010). Another group consists of those who maintain a low or undetectable viral load without anti-retroviral treatment, known as "elite controllers" or "elite suppressors". They represent approximately 1 in 300 infected persons (Walker, 2007).

1.3.3.3 Acquired Immunodeficiency syndrome:
Main symptoms of AIDS

Acquired Immunodeficiency Syndrome (AIDS) is defined in terms of either a CD4+ T cell count below 200 cells per µL or the occurrence of specific diseases in association with an HIV infection (Mandell, Bennett, & Dolan, 2010). In the absence of specific treatment, around half of people infected with HIV develop AIDS within ten years (Mandell, Bennett, & Dolan, 2010). The most common initial conditions that alert to the presence of AIDS are pneumocystis pneumonia (40%), cachexia in the form of HIV wasting syndrome (20%), esophageal candidiasis, and recurring respiratory tract infections (Mandell, Bennett, & Dolan, 2010).

Opportunistic infections may be caused by bacteria, viruses, fungi, and parasites that are normally controlled by the immune system (Holmes, Losina, Walensky, Yazdanpanah, & Freedberg, 2003). These infections may affect nearly every organ system (Chu & Selwyn, 2011).

People with AIDS have an increased risk of developing various viral-induced cancers, including Kaposi's sarcoma, Burkitt's lymphoma, primary central nervous system lymphoma, and cervical cancer (Vogel, Schwarze-Zander, Wasmuth, Spengler, Sauerbruch, & Rockstroh, 2010). Kaposi's sarcoma is the most common cancer occurring in 10 to 20% of people with HIV (Mandell, Bennett, & Dolan, 2010). The second most common cancer is lymphoma, which is the cause of death of nearly 16% of people with AIDS and is the initial sign of AIDS in 3 to 4% (Mandell, Bennett, & Dolan, 2010). Both these cancers are associated with human herpesvirus (Mandell, Bennett, & Dolan, 2010). Cervical cancer occurs more frequently in those with AIDS because of its association with human papillomavirus (HPV) (Mandell, Bennett, & Dolan, 2010). Conjunctival cancer (of the layer that lines the inner part of eyelids and the white part of the eye) is also more common in those with HIV (Mittal, Rath, & Vemuganti, 2013).

Additionally, people with AIDS frequently have systemic symptoms such as prolonged fevers, sweats (particularly at night), swollen lymph nodes, chills, weakness, and unintended weight loss (“AIDS”. Medline Plus, 2012). Diarrhoea is another common symptom, present in about 90% of people with AIDS (Sestak, 2005). They can also be affected by diverse psychiatric and neurological symptoms independent of opportunistic infections and cancers (Murray, Buttner, & Price, 2012).
1.4 Clinical Staging of HIV/AIDS

Revised World Health Organization (WHO) Clinical Staging of HIV/AIDS for Adults and Adolescents (2005)

The clinical staging and case definition of HIV for resource-constrained settings were developed by the WHO in 1990 and revised in 2007. Staging is based on clinical findings that guide the diagnosis, evaluation, and management of HIV/AIDS, and it does not require a CD4 cell count. This staging system is used in many countries to determine eligibility for antiretroviral therapy, particularly in settings in which CD4 testing is not available. Clinical stages are categorized as 1 through 4, progressing from primary HIV infection to advanced HIV/AIDS. These stages are defined by specific clinical conditions or symptoms. For the purpose of the WHO staging system, adolescents and adults are defined as individuals aged ≥15 years. Two main clinical staging systems are used to classify HIV and HIV-related disease for surveillance purposes: the WHO disease staging system for HIV infection and disease (World Health Organization, 2007), and the CDC classification system for HIV infection (Schneider, Whitmore, Glynn, Dominguez, Mitsch, & McKenna, 2008; Centers for Disease Control and Prevention, (CDC, 2008). The CDC’s classification system is more frequently adopted in developed countries. Since the WHO’s staging system does not require laboratory tests, it is suited to the resource-restricted conditions encountered in developing countries, where it can also be used to help guide clinical management. Despite their differences, the two systems allow comparison for statistical purposes (Mandell, Bennett, & Dolan, 2010; Schneider, Whitmore, Glynn, Dominguez, Mitsch, & McKenna, 2008; World Health Organization, 2007).

The World Health Organization proposed the first definition for AIDS in 1986. Since then, the WHO classification has been updated and expanded several times, with the most recent version being published in 2007. The WHO system uses the following categories:

- Primary HIV infection: May be either asymptomatic or associated with acute retroviral syndrome (World Health Organization, 2007).
- Stage I: HIV infection is asymptomatic with a CD4+ T cell count (also known as CD4 count) greater than 500 per microlitre (µl or cubic mm) of blood. It includes generalized lymph node enlargement (World Health Organization, 2007).
Chapter 1: Introduction

- Stage II: Mild symptoms which may include minor mucocutaneous manifestations and recurrent upper respiratory tract infections. A CD4 count of less than 500/µl (World Health Organization, 2007).

The symptoms include, moderate and unexplained weight loss (<10% of presumed or measured body weight), recurrent respiratory tract infections (such as sinusitis, bronchitis, otitis media, pharyngitis), herpes zoster, recurrent oral ulcerations, papular pruritic eruptions, angular cheilitis, seborrhoeic dermatitis, and onychomycosis (fungal nail infections).

- Stage III: Advanced symptoms which may include unexplained chronic diarrhoea for longer than a month, severe bacterial infections including tuberculosis of the lung, and a CD4 count of less than 350/µl (World Health Organization, 2007).

- Stage IV or AIDS: severe symptoms which include toxoplasmosis of the brain, candidiasis of the esophagus, trachea, bronchi lungs, Kaposi's sarcoma and a CD4 count of less than 200/µl (World Health Organization, 2007).

1.4.1 Immunological Staging of HIV Infection

Clinical staging can be used effectively without access to CD4 or other laboratory testing. However, CD4 testing is useful for determining the degree of immune compromise, and where CD4 facilities are available they should be used to support and reinforce clinical decision-making. Data on CD4 levels are not a prerequisite for starting ART and should only be used in conjunction with consideration of the clinical stage.
The United States Centers for Disease Control and Prevention also created a classification system for HIV, and updated it in 2008 and 2014 (Schneider, Whitmore, Glynn, Dominguez, Mitsch, & McKenna, 2008; Centers for Disease Control and Prevention, (CDC), 2014). This system classifies HIV infections based on CD4 count and clinical symptoms, and describes the infection in five groups (Centers for Disease Control and Prevention, (CDC), 2014) in those greater than six years of age it is (Centers for Disease Control and Prevention, (CDC), 2014):

- **Stage 0:** the time between a negative or indeterminate HIV test followed less than 180 days by a positive test
- **Stage 1:** CD4 count ≥ 500 cells/µl and no AIDS defining conditions
- **Stage 2:** CD4 count 200 to 500 cells/µl and no AIDS defining conditions
- **Stage 3:** CD4 count ≤ 200 cells/µl or AIDS defining conditions
- **Unknown:** if insufficient information is available to make any of the above classifications

For surveillance purposes, the AIDS diagnosis still stands even if, after treatment, the CD4\(^+\) T cell count rises to above 200 per µL of blood or other AIDS-defining illnesses are cured (Mandell, Bennett, & Dolan, 2010).
1.4.2 Receiving an HIV-positive diagnosis

Previous research indicates that testing for HIV, and especially receiving an HIV-positive diagnosis can be an extremely stressful and life-changing experience. In particular, people experience various short- and long-term emotional and behavioural reactions immediately after being diagnosed with HIV. With regard to emotional reactions, previous researches have identified the following reactions:

- shock (Amuyunzu-Nyamongo, Okeng’o, & Wagura, 2007; Hult, Maurer, & Moskowtiz, 2009; Pittiglio & Hough, 2009)
- surprise and disbelief (Hult, Maurer, & Moskowtiz, 2009)
- anger and fear (Reeves, Merriam, & Courtenay, 1999)
- denial (Medley, Kennedy, Lunyolo, & Sweat, 2009; Pittiglio & Hough, 2009; Sorajjakool, 2006)
- deep sadness (Hult, Maurer, & Moskowtiz, 2009; Sorajjakool, 2006)
- suicide ideation (Hult, Maurer, & Moskowtiz, 2009; Plattner & Meiring, 2006; Sorajjakool, 2006)
- guilt and bereavement (Holt, Court, Vedhara, Nott, Holmes, & Snow, 1998)
- disorientation and derealisation (Stevens & Doerr, 1997).

A number of behavioural reactions have been identified, such as:

(a) the inability to move (Stevens & Doerr, 1997)
(b) blurry vision (Sanders, 2008)
(c) dizziness, numbness, needing to leave the testing site immediately, feeling that the room is spinning, dry mouth, sweating, inability to hear anything the counsellor said after hearing the result, and crying (Hult, Maurer, & Moskowtiz, 2009).

Moreover, newly diagnosed individuals may start to isolate themselves (Nyanzi-Wakholi, Lara, Watera, Munderi, Gilks, & Kurthet, 2009; Sanders, 2008; Stevens & Doerr, 1997), mentally and behaviourally disengage (Reeves, Merriam, & Courtenay, 1999), abuse alcohol and drugs (Reeves, Merriam, & Courtenay, 1999; Stevens & Doerr, 1997), keep their HIV-positive status secret (Holt, Court, Vedhara, Nott,
Holmes, & Snow, 1998) and practise risky sexual behaviour (Reeves, Merriam, & Courtenay, 1999). However, some newly diagnosed individuals may react to the news of their HIV-status more positively, by seeking social support (Holt, Court, Vedhara, Nott, Holmes, & Snow, 1998; Hult, Maurer, & Moskwitz, 2009)), seeking information about HIV and AIDS (Hult, Maurer, & Moskwitz, 2009; Reeves, Merriam, & Courtenay, 1999) practising safer sexual behaviour (Holt, Court, Vedhara, Nott, Holmes, & Snow, 1998; Stevens & Doerr, 1997), and disclosing their HIV-positive status to others (Amuyunzu-Nyamongo, Okeng’o, & Wagura, 2007; Holt, Court, Vedhara, Nott, Holmes, & Snow, 1998).

1.5 Spiritual Distress: Concept, Meaning and Definitions

Human beings are complex, with physical, mental, and spiritual aspects. Suffering can result from issues pertaining to any of these aspects. Spiritual distress is a state of suffering due to spiritual causes. For example: a mother having difficulty understanding why a loving God would allow her child to die (Anandarajah, 2005). The spiritual distress refers to the existential anguish experienced by patients when their belief system cannot provide relief. When patients suffer, they experience a sense of their own vulnerability and finitude, as well as a disruption and fracture of their own person and sense of community. As a result, the experience of suffering can be an opportunity to experience his own spirituality (Markwell, 2005). When well-constructed, the belief structure is a source of comfort, welfare, security, meaning, idealism and force.

Anandarajah and Hight (2001) note that “spiritual distress and spiritual crisis” occur when a person is “unable to find sources of meaning, hope, love, peace, comfort, strength, and connection in life or when conflict occurs between their beliefs and what is happening in their life.”

Carpenito (2002) defines spiritual distress as “a disturbance in the belief or value system that provides strength, hope and meaning to life” –as one general nursing diagnosis related to spirituality. Additional characteristics of spiritual distress include questioning the meaning of life, death and suffering, questioning credibility of the belief system, discouragement or despair, and emotional detachment from others and self. Factor that contributes to spiritual distress may be pathologic, treatment-related or situational (e.g., death or illness of the significant other) (Street & Carpenitio, 2002; Van Dover & Bacon, 2001).
Gulanick, Myers, and Klopp (2003) define spiritual distress as an experience of profound disharmony in the person’s belief or value system that threatens the meaning of life. During spiritual distress, the patient loses hope, questions his or her belief system, or feels separated from his or her personal source of comfort and strength. Pain, chronic terminal illness, impending surgery, death or illness of a loved one are crises that may cause spiritual distress. Being physically separated from family and familiar culture contribute to feeling alone and abandoned.

Spiritual distress is also called spiritual suffering and is present in different moments of the life of an individual when someone “experiences a disorder in his system of values and beliefs that gives him hope, strength and meaning to life (Pallares & Abordaje, 2004). The most favourable time to experience this phenomenon is when an individual experiences a moment of pain and, in most reports, this happens after the discovery of the diagnosis of an illness, especially a chronic disease like cancer, which can be life threatening (Kawa, Kayama, Maeyama, Iba, Murata, & Imamura, 2003).

Spiritual distress can be defined as “a state in which the individual is at risk of experiencing a disturbance in his/her system of belief or value that provides strength, hope, and meaning to life” (Carpenito-Moyet, 2004). This is also associated with more severe depression and desire for hastened death in end-of-life patients (McClain, Rosenfeld, & Breitbart, 2003; Rodin, Lo, Mikulincer, Donner, Gagliese, & Zimmermann, 2009).

Wilkinson (2005, p. 507) defines spiritual distress as impaired ability to experience and integrate meaning and purpose in life through a person’s connectedness with self, others, art, music, literature, nature, or a power greater than oneself. Spiritual distress is one of the most common nursing diagnoses to result from a spiritual assessment. The North American Nursing Diagnosis Association (NANDA) has specifically identified spiritual distress as a diagnosis (Young & Koopsen, 2005, p. 9).

Chaves, Carvalho, Goyata, and Galvao (2008) proposed an alteration of the definition and diagnosis label after reviewing the literature. They define it as a disturbance in meaning and purpose in life; disturbance in connection to self, God/power greater than self, others, and world; and disturbance in transcendence. The origins of spiritual distress are linked with spirituality, which is a characteristic dimension of human beings’ existence and integrates all human being dimensions.
A Nursing Diagnosis approved by the North American Nursing Diagnosis Association (2010), defines spiritual distress as “disruption in the life principle that pervades a person’s entire being and that integrates and transcends his or her biological and psychosocial nature”. The person experiencing spiritual distress may express concern with the meaning of life and death, question the meaning of suffering or of his or her own existence, verbalize inner conflict about beliefs, express anger toward God or other Supreme Being, or actively seek spiritual assistance.

Chapter 8 in the Essentials of Correctional Nursing discusses spiritual distress in the correctional population which provides cues to identify the condition and recommends nursing interventions to address spiritual distress. NANDA defines the spiritual distress diagnosis as “the impaired ability to experience and integrate meaning and purpose in life through connectedness with self, others, art, music, literature, nature, and/or a power greater than oneself” (NANDA, 2010).

1.5.1 Signs of spiritual distress

- Sadness, anger, despair, depression, anxiety.
- Asks why this is happened, “Why now?”, “Why me?”
- Questioning the meaning of life and/or death
- Questioning the meaning of suffering
- A sense of emptiness or loss of direction
- Hopelessness or deep despair
- Fear of falling asleep at night or other fears
- Crying, or rage
- Bringing on unwanted consequences (absenteeism or incompetence resulting in job loss)
- Suicidal thoughts
- Preoccupations with pregnancy or getting pregnant again
- Nightmares Questioning your own belief system
- Anger at God/higher power
- Feeling abandoned by God/higher power
- Seeking spiritual help or guidance
• Pain and other physical symptoms that cannot be helped with medications or other medical treatment

1.5.2 Symptoms of Spiritual Distress

**Physical Symptoms**

• Depression
• Infection
• Excessive bleeding
• Fertility complications
• Increase risk of miscarriage in subsequent pregnancies
• Sleep, appetite and sexual disturbances
• Mutilation of female organs and/or genitalia
• Untreated severe bleeding or infection

**Emotional symptoms**

• Self-destructive abuses of drugs, alcohol, food
• Cutting, self-mutilation
• Promiscuity
• Neglecting health
• Unexplained depression

• Trigger events produce an increase in symptoms. These events can include the following: Mother’s Day, a baptism, Christmas, pregnant women, menopause, the sound of a vacuum cleaner, a baby crying, the sight of doctors’ offices, bleeding, fetal pictures, the smell of cologne, food, disinfectants associated with the abortion, a touch from doctor, or intercourse.

**Spiritual symptoms**

• Feeling alienated from God
• Withdrawal from Lord’s Supper, church, pastor and church friends
• "If the people at church knew, they would think I’m such a hypocrite"
• Inability or reluctance to pray
Survival guilt "It was me or you and I chose me"

Inability to believe God’s forgiveness is for her; despair of God’s mercy

Anger at God for not stopping her pregnancy or for not stopping her from having the abortion

Belief that God will punish her

**Relational symptoms**

- 80% of the intimate relationships leading to pregnancy end after an abortion

- Friendships and familial relationships become more stressed due to complicity in the abortion decision or due to the shame and secrecy of having the abortion

- Repeatedly entering and/or sustaining destructive and abusive intimate relationships

- Inability to bond properly with current or future children.

### 1.5.3 Defining Characteristics

There are several defining characteristics associated with spiritual distress. They are: alienation or isolation, question of suffering, alteration in behaviour, crying, withdrawal, preoccupation, anxiety, hostility, apathy, anger, inability to express creativity, lack of meaning/purpose in life, lack of serenity, lack of courage, lack of hope, guilt, refuse interactions with significant others, being abandoned, feeling of regret, requests for spiritual assistance, inability to experience transcendence, present disorders in the system of beliefs or relationship with God, having anger toward God, lack of love, despair and disinterest in nature, concern with meaning of life/death and/or belief systems, questions moral/ethical implications of therapeutic regimen, describes nightmares/sleep disturbances, verbalizes inner conflict about beliefs, verbalizes concern about relationship with deity, unable to participate in usual religious practices, seeks spiritual assistance, questions the meaning of suffering, questions meaning of own existence, displacement of anger toward religious representatives, anger toward God and gallows humour (inappropriate humour in a grave situation).
Common concerns that may cause spiritual distress:

- Distance from a person’s religious or spiritual community
- Need to reconcile with God, others, and self
- Spiritual beliefs being different from family, peers and/or healthcare team
- Lack of access to religious or spiritual rituals
- Distress and/or despair anxiety related to the struggle to find meaning in the experience of illness, suffering, death and dying

1.5.4 Elements of Spiritual Distress

Kliewer and Saultz (2006) addressed the specific elements of spiritual distress or pain in their book, *Healthcare and Spirituality*. They delineate the different emotional and spiritual states a patient with an illness, or anyone having a spiritual crisis, can experience and how to deal with them. The list includes the following:

(a) **Helplessness** is a feeling that no help is available either from within one’s own self or own resources or from other people or from anywhere in the outside world. The patient has a sense that nothing can be done and all control is lost. People who believe in God may even feel that God has abandoned them. People who have a feeling of hopelessness have no belief or trust in the future, cannot see possibilities, and consequently experience despair. They lost their sense that anything can ever change or is worth struggling for. If a patient loses their hope so their chance of recovery or even survival markedly decreases.

(b) **Anger** can occur as a part of spiritual distress. It may be expressed as resentment, frustration, annoyance, or exasperation. The anger can be against the disease, family, friends, people in general, and the world, or God. It can also be turned inward against oneself. Anger can be very destructive and sap one of energy. It can dissociate the patient from other people and from one’s valued and reassuring sacred beliefs. It can damage one’s physical health and prevent one form healing. It can block insight that fosters a healing process and keep the patient from developing a spiritual side.

(c) **Guilt** can be a very destructive force and a huge part of spiritual distress and pain. In fact, it can even be encouraged by organized religion’s beliefs and practices. Guilt results from a feeling of not living up, to one’s own expectations, or society’s
expectations, or what the patient may perceive as God’s expectations. In some cases, guilt can lead to re-evaluation of one’s values and actions and result in positive correction and change. But if guilt is unreasonable and nothing but punishment-oriented, it can lead to shame, a sense of worthlessness, and inactivity. Guilt can cause emotional pain and a sense of being lost. In an extreme form, guilt can make a patient see an illness as a punishment.

(d) **Fear, anxiety,** and a **sense of meaninglessness** can all be an expression of spiritual distress. There may be fear of the unknown, fear of what lies ahead, fear of death, fear of loss of self. There may be generalized anxiety associated with the sense of one’s life falling apart or the lack of any direction in one’s life. It is easy to take the next step of regarding life as meaningless. Questions such as “Why live if you have to die?”, “Why do I have to suffer?”, “Why are we even here?”, “Does God really care?”, “Does anyone make a difference in the long run?” come up.

(e) Finally, **disconnectedness** can be a significant and painful part of spiritual distress. The patient may feel disconnected from family, friends, him/herself, the world, and the sacred part of life. There may be a sense of unworthiness, because of the feelings and thoughts associated with being disconnected, and the patient may not want to connect emotionally with anyone. Patients may find it difficult to cooperate with or even listen to healthcare professionals. It may lead to an uncomfortable sense of isolation.

Patients with chronic illnesses often face an array of difficulties and stressors, such as pain, feelings of uncertainty, and changes in body image, because these illnesses cannot be cured; only managed. These kinds of stressors can lead to changes in well-being, to spiritual distress, and to the struggle with existential questions such as “what is the meaning of life?” (O’Neill & Kenny, 1998). Often these individuals search for relevant meaning and purpose in life, which may, in turn, bring out unresolved conflicts with other people and regret about certain life choices. The inability to resolve spiritual distress may then lead to spiritual conflict, spiritual anger, spiritual guilt and spiritual disengagement.

**Spiritual Conflict:** This refers to the idea that the participant is definitely spiritual, but disagrees with, or breaks rules/doctrines dictated by spiritual beliefs. Spiritual conflict can involve questioning previously held beliefs.
Chapter 1: Introduction

Spiritual Anger: Participants who express frustration or outrage at God for having allowed illness or other trials, comments about the “unfairness” of God, and/or negative remarks about institutionalized religion and/or its ministers or spiritual care givers. This refers to the idea that the participant harbours negative emotions towards spiritual communities/ spiritual presence. For example, the participant is angry with God, blames God for his misfortunes, etc. This could also refer to participants who express feelings of hostility towards spiritual communities, or they feel ostracized, rejected, etc. by them.

Spiritual Guilt: Participants who express worry that God is displeased with one’s behaviour. Also, participants might express failure to do the things which he feels he should have done in life and/or done things which were not pleasing to God. Examples include expressing that one should attend Church, that one should engage in more spiritual practices, one should not do things that are against their spiritual beliefs, etc.

Spiritual Disengagement: Because of our broad definition of spirituality, spiritual disengagement goes beyond disengaging in the practice of religious behaviors. Examples include disengagement in prayer, reading of religious or spiritual material (spiritual material can be anything the participant considers sacred; e.g. reading scientific literature about aliens if this represents a connection to something higher or sacred, attending organized religious events, performing religious or spiritual rituals, etc.). Spiritual disengagement can be beneficial or detrimental to the individual’s physical and mental health. For example, upon receiving an HIV diagnosis, disengaging spiritually might be detrimental if the individual blames the higher power (e.g., God why have you forsaken me?) as opposed to thinking there is a higher purpose for becoming infected with the disease (e.g. God’s will). However, disengaging in spirituality can be beneficial if, for instance, a homosexual man discloses his status in the Church to which he belongs and becomes ostracized as a result; refraining from Church attendance would then qualify as a form of spiritual disengagement.
1.5.5 Types of Spiritual Distress

There are seven types of spiritual distress (Mary Elizabeth O’Brien, 1982):

(a) **Spiritual Pain** often evidenced by expressions of discomfort and suffering, having a void or lack of spiritual fulfilment, and/or lack of peace in regard to one’s relationship with God.

(b) **Spiritual Alienation** often stemming from feelings of loneliness or the feeling that God seems very far away and remote from one's everyday life, verbalization or thoughts that one has to depend upon one's self in times of trial or need, and/or a negative attitude toward receiving any comfort or help from God.

(c) **Spiritual Anxiety** frequently manifested by expressions of fear of God's wrath and punishment, fear that God might not take care of one (either immediately or in the future), and/or worry that God is displeased with one's behaviour.

(d) **Spiritual Guilt** frequently detectable by expressions suggesting that one has failed to do the things one should have done in life and/or done things which were not pleasing to God and/or articulation of concerns about the "kind of life" one has lived.

(e) **Spiritual Anger** many times noticeable by expressions of frustration or outrage at God for having allowed illness or other trials, comments about the “unfairness of God”, and/or negative remarks about institutionalized religion and its ministers and spiritual caregivers.

(f) **Spiritual Loss** commonly discernible by expressions of having temporarily lost or terminated the love of God, fear that one's relationship with God has been threatened, and/or feelings of emptiness with regard to spiritual things.

(g) **Spiritual Despair** generally determined by expressions suggesting that there is no hope of ever having a relationship with God or of pleasing God and/or a feeling that God no longer can or does care for one.
1.6 Coping: Meaning and Definitions

In psychology, “coping is expending conscious effort to solve personal and interpersonal problems, and seeking to master, minimize or tolerate stressor conflict” (Lazarus & Folkman, 1984; Mark, Greene, & Karraker, 1991; Snyder, 1999; Weiten & Lloyd, 2008; Zeidner & Endler, 1996). The level of coping depends much on the stress types, conflict types, individual and circumstance of the stress/conflict.

Coping is a problem solving behaviour which brings about a state of equilibrium in the disturbed by the impact of anxiety. Psychological coping mechanisms are commonly termed as coping strategies or coping skills. Coping refers to adaptive or constructive coping strategies, i.e. the strategies which reduce stress levels. However, some coping strategies can be considered as maladaptive, i.e. it increases the level of stress. Maladaptive coping can be considered as dysfunctional. Furthermore, thus the term coping usually refers to reactive coping, which means the coping response stick to the stressor. This differs with proactive coping, in which a coping response seeks to head off a future stressor.

Coping is defined as “the cognitive and behavioural efforts made to master, tolerate or reduce external and internal demands and conflicts among them” (Lazarus & Folkman, 1980). Lazarus and Folkman (cited in Rose & Clark-Alexander, 1999) define coping as “a person’s constantly changing cognitive and behavioural efforts (used) to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of a person” (p. 337). Coping is defined as “constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984).

Pearlin and Schooler (1978) define coping as a “behaviour that protects people from being psychologically harmed by problematic social experience, a behaviour that importantly mediates the impact that societies have on their members” (p. 2). They add that “coping, in sum, is certainly not unidimensional behaviour. It functions at a number of levels and is attained by a plethora of behaviours, cognitions, and perceptions” (Pearlin & Schooler, 1978). This definition highlights that coping is a multifaceted psychological construct that includes not only behaviour, but also cognitions. Furthermore, Pearlin and Schooler (1978) note that coping is aimed at protecting people against psychological harm.
Coping refers to a set of cognitive and behavioural strategies which individuals use to cope with stress situations (Panzini & Bandeira, 2007). When using religious resources as an alternative to cope with adverse health conditions, the patient is using religious coping (Melaggi, 2009), which can be defined as the use of religious beliefs to understand and deal with the stressing agents of life (Pargament, Koenig, & Perez, 2000). Coping is a vast concept that includes numerous behavioral, cognitive and affective responses. Consequently, a great number of coping styles have been identified (Skinner, Edge, Altman, & Sherwood, 2003).

Coping is a very complex process that varies according to many variables such as the situation, the evaluation of the situation, and the resources available. Coping strategies refer to the specific efforts, both behavioral and psychological, that people employ to master, tolerate, reduce, or minimize stressful events.

Coping refers to the thoughts and actions we use to deal with a threatening situation. A stressful situation may be considered a threat for you but not necessarily for your neighbour. You and your neighbour may become stressed by the same situation, but for different reasons (e.g. the situation is new for you, but unpredictable for your neighbour). After all, since we all become stressed for various reasons we will need to choose different coping strategies.

1.7 Coping with HIV

Kubler-Ross (1969) identifies five stages of adjusting to the diagnosis of a terminal illness:

- The first stage is **denial**, which entails the unwillingness to accept the reality of the diagnosis. Denial is usually accompanied by negative emotions such as shock and fear.
- The second stage is **anger**. As denial decreases and the person starts to face the reality of the diagnosis, anger and bitterness may develop. The person may become angry at other people, healthy people and even God.
- The third stage is **bargaining**. In this stage, the person decides to bargain, often with God, to receive improved health and more time to live in exchange for better behaviour. People in this stage may become uncharacteristically charitable and pleasant.
• The fourth stage is depression. In this stage the person acknowledges that little can be done about the situation. As a result, psychological distress may increase and physical health may decrease in this stage.

• The fifth stage is acceptance and entails the acceptance of the diagnosis and deteriorating physical health. At this stage, people may be too weak to be depressed or angry and may alternatively become more at peace with their situation (Kubler-Ross, 1969).

Although these stages of adjustment may be useful in exploring coping over time, it must be noted that with the advent of ARVs, HIV-infection and AIDS is generally no longer considered to be a terminal illness, and people living with HIV may live for many years after becoming infected with HIV (Coetzee & Spangenberg, 2003). Kubler-Ross’s (1969) stages of adjustment may therefore not necessarily be directly reflected in the way people who live with HIV cope with their HIV positive status.

HIV/AIDS people experience extended emotions and psychological reaction and use various coping mechanism (Chida & Vedhara, 2009). However, whether there is a specific developmental course similar to Kubler-Ross’s stages in the way coping strategies are used over time by people living with HIV is still uncertain. It has been suggested that changes in the way coping strategies are used over time may be linked to HIV disease progression, the presence of AIDS-related symptoms, changing levels of psychological and spiritual distress and earlier use of coping strategies (Chida & Vedhara, 2009; Fleishman, Sherbourne, Cleary, Wu, Crystal, & Hays, 2003; Moneyham, Hennessy, Sowell, Demie, Seals, & Mizuno, 1998).

Seeking social support became a more prominent coping strategy at this stage in the participants’ lives. The participants reported that seeking social support immediately after diagnosis was difficult for them, as they seldom engaged in social support prior to their diagnosis and felt like they did not need it. Additionally, participants indicated that after being diagnosed with HIV, they realised that they do not have to be in control all the time and started to be more open to being in supportive relationships where support was provided and received (Reeves, Merriam, & Courtenay, 1999). They found distinct changes in the focus of coping strategies as were used over time by their participants. It was found that immediately after
diagnosis coping strategies tended to be more reactive as participants responded to the threat of the diagnosis and dealt with intense emotions. As time progressed, coping strategies became more proactive as participants started to confront their situations more actively. It was also found that coping strategies immediately after diagnosis were indicative of less control, as participants perceived that they had little control over their behaviour and situations. Over time, participants gained a greater sense of empowerment and coping strategies became more indicative of greater control. Lastly, coping strategies immediately after diagnosis were found to be more self-centred, but became progressively more other-centred over time (Reeves, Merriam, & Courtenay, 1999).

HIV-positive adults also report using drugs to cope with stressful situations and with emotional distress. In a qualitative study exploring motivations of methamphetamine use in HIV-positive gay men, participants explained that drugs were used to self-medicate the negative affect associated with having HIV (Semple, Patterson, & Grant, 2002).

If one family member exhibit signs and symptoms of HIV, the entire family may face rejection and even violence from the community. The loss of social support results in isolation for the family, which may also fear loss of employment, denial of school admission, or denial of adequate housing. Stigma can attach to children of HIV-infected parents and to orphans whose parents died of AIDS.

Many people living with HIV/AIDS find it challenging to attend to daily tasks of living, participate in moderate to vigorous physical activities, or to have sufficient energy or vitality to engage in an active social life while managing HIV/AIDS. Fatigue or low energy has been associated with both physical and psychological morbidity (Breitbart, McDonald, Rosenfeld, Monkman, & Passik, 1998) and poor quality of life in persons with HIV/AIDS. In addition, fatigue and a CD4 T-cell count less than 500 are associated with physical limitations and disability (Ferrando, Evan, Goggin, Sewell, Fishman, & Rabkin, 1998). Among HIV patients, disease progression is related to decreasing energy and increasing difficulties with daily activities and pain (Sarna, van Servellen, Padilla, & Brecht, 1999).
1.8 Types of Coping Strategies

Hundreds of coping strategies have been identified. Classification of these strategies into a broader architecture has not yet been agreed upon. A brief discussion of coping styles in the H1V literature is now follows.

1.8.1 Problem and emotion-focused coping


**Problem-focused coping** is defined as “coping that is aimed at managing or altering the problem causing the distress” (Lazarus & Folkman, 1984, p. 150). Problem-focused coping includes coping strategies such as problem-solving and planning. These coping strategies are directed at both the environment and at the self with the aim of addressing the stressful situation. Strategies directed at the environment include modifying resources, obstacles and any other environmental entities that may be contributing to the problem. Strategies directed at the self generally involve motivational and/or cognitive alterations. Problem-focused coping is usually employed when the individual appraises that something can still be done to change the stressful situation (Lazarus & Folkman, 1984).

**Emotion-focused coping** is defined as “coping that is directed at regulating emotional responses to the problem” (Lazarus & Folkman, 1984, p. 150). Emotion-focused coping includes coping strategies such as venting of emotions, distraction and emotional support. Emotion-focused coping strategies are mostly defensive in nature and are directed at the negative emotions that the stressful situation generates. Utilizing emotion-focused coping strategies may not change the meaning of the problem or be aimed at addressing the problem directly, but instead is aimed at minimizing the emotional distress that the person is experiencing. These coping strategies are mostly used when the individual appraises that nothing can be done to change the stressful situation. Although emotion-focused coping is aimed at dealing with the negative emotions associated with the stressor and make the person feel better, some emotion-focused coping strategies may be counterproductive and lead to more emotional distress (Lazarus & Folkman, 1984).
Apart from the problem-focused and emotion-focused distinction, a number of other coping style distinctions have been made. A brief discussion on engagement and disengagement coping as well as meaning-focused coping and other prominent coping styles in the coping literature now follows.

1.8.2 Engagement and disengagement coping

Compass, Connor-Smith, Saltzman, Thomsen, and Wadsworth (2001) define engagement coping as “responses that are oriented toward either the source of stress, or toward one’s emotions and thoughts” (p. 92). Disengagement coping is defined as “responses that are oriented away from the stressor or one’s emotions or thoughts” (Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001, p. 92). Engagement coping is sometimes referred to as confrontation, vigilant or active coping and is similar to certain problem-focused coping strategies. Disengagement coping is similar to avoidant and minimization coping as well as some emotion-focused coping strategies (Carver & Connor-Smith, 2010; Taylor, 2003). Engagement coping includes strategies such as seeking social support, acceptance and positive refraining, whereas disengagement coping includes strategies such as substance use, distraction and denial (Carver & Connor-Smith, 2010). Engagement coping can further be divided into primary and secondary-control coping. Primary-control coping refers to controlling the stressful situation which includes direct action and planning. Secondary-control coping refers to adjusting to the stressful situation, relates more to positive reframing and acceptance (Skinner, Edge, Altman, & Sherwood, 2003).

1.8.3 Meaning-focused coping

Meaning-focused coping is also referred to as benefit finding, positive growth and positive reappraisal and is often linked with spirituality and religion. Meaning-focused coping involves the positive reappraisal of stressful situations by connecting positive meanings to these situations. To this end, beliefs and values form the basis of meaning which is then superimposed on stressful situations to assist people in finding meaning in the situation and to see the positive side to the stressful situation (Carver & Connor-Smith, 2010) Meaning-focused coping is generally used more to cope with stressful situations that are considered to be uncontrollable and unchangeable (Folkman, 2008).
1.9 Spiritual-Religious Coping

To cope with the challenges associated with HIV/AIDS, many people rely on spirituality (Lorenz, Hays, Shapiro, Cleary, Asch, & Wenger, 2005). When people turn to their spirituality to cope with stress, they use spiritual coping. Spirituality is a coping mechanism and can be used by patients to transcend illness and suffering (Emblem & Halstead, 1993). Words such as spirituality and religion carry a variety of meanings for different people. Not all S-R coping is positive. S-R perceptions and spiritualitly may well be a double-edged sword. Although much of the literature is suggestive of an overall positive effect of religion on health, at times religious practice might have a deleterious effect. What appears to be ultimately important in terms of health outcome is not religious involvement (e.g. church attendance) but how people actually deploy their religious beliefs to cope with adversity.

Spiritual-Religious (S-R) coping is the use of religious beliefs, attitudes or practices to reduce the emotional distress caused by stressful events of life, such as loss or change, which gives suffering meaning and makes it more bearable. Religious beliefs and practices are used to regulate emotion during times of illness, change, and circumstances that are out of patients’ personal control (Koenig, 2002).

Spirituality and religion are prevalent coping strategies both for physical and for mental illness. For many patients’ religion and spirituality play a significant role in their lives and may help them cope with their symptoms. Patients’ personal beliefs may be fundamental to their sense of well-being and could help them to cope with negative aspects of illness or treatment. However, incorporating spirituality into medical practice continues to pose many challenges. Spirituality is often seen as a private and subjective area that lies outside of the therapeutic context, but patients’ beliefs can have a substantial impact on construction of the meaning of illness, coping behaviour, and preferences about treatment.

Positive religious/spiritual coping are reflective of benevolent religious method of understanding and dealing with life stressors, negative religious/spiritual coping reflective of religious struggle in coping. Empirical studies have shown a clear connection between stressful life events and various forms of religious/spiritual involvement (Bearon & Koenig, 1990; Bjork & Cohen, 1993; Ellison & Taylor, 1996)
Most studies focus on the positive aspects of spirituality that emphasizes a secure relationship with God and a belief in a larger, benevolent purpose to life. In contrast, spiritual struggles are the result of a more tenuous relationship with God, a more ominous view of life, and a sense of disconnectedness with the spiritual community. Feelings of stigma, shame, and guilt associated with HIV and perpetuated by religious institutions can evoke spiritual struggles.

This form of coping is goal-directed as it is directed at defining the problem, generating alternative solutions, weighing costs and benefits, and then choosing and acting on a solution. Examples of confrontive coping include bargaining, focusing on the positive, social support, and concentration of efforts (Sarafin in Melnick, 2004).

The study of religious/spiritual coping should be broad and based on a functional view of religion and its functions in coping. Thus, five key-functions of religion can be identified: search for meaning, control, spiritual comfort, intimacy with God and with others and the search to transform life. Based on each of these five basic functions, religious coping methods or strategies can be identified (Pargament, Koenig, & Perez, 2000). Although the religious coping concept entails positive connotations, it can be positive as well as negative; similarly, religious/spiritual coping strategies can be classified as positive and negative (Pargament, Koenig, & Perez, 2000).

Religious/spiritual coping comprises measures that exert beneficial effects on individuals, like seeking protection from God or a greater connection with transcendent forces, seeking comfort or help in religious literature, among others. Negative religious/spiritual coping, then, is related to measures that cause harmful consequences for individuals, like questioning God’s existence, delegating the solution of problems to God, defining the stress condition as a punishment from God, among others (Panzini & Bandeira, 2007; Pargament, Koenig, & Perez, 2000).

Spirituality (Bonanno & Kaltman, 2001) for many individuals extends beyond a “means of coping” to a “way of being” that is foundationally rooted in every aspect of the individual’s living and dying processes (Kwilecki, 2004; Puchalski, 2002).

Spirituality is a powerful tool for coping because elements of spirituality play crucial roles throughout the coping process (Pargament, 1997). Several study findings have highlighted the importance of spirituality in coping with HIV-related stressors (Tarakeshwar, Hansen, Kochman, & Sikkema, 2005) such as the loss of a loved one.
to AIDS (Richards, Acree, & Folkman, 1999), overcoming guilt and shame for engaging in risky behaviors (Kaldjian, Jekel, & Friedland, 1998), and finding a sense of purpose in life (Siegel & Schrimshaw, 2002). Higher levels of spirituality have also been related to long-term survival with HIV (Barroso, 1999; Ironson, O’Cleirigh, Kumar, Balbin, Schneiderman, & Fletcher 2006; Ironson & Kremer, 2009). While there is research that examines the impact of spiritual coping on health outcomes, mental well-being, and quality of life in PWH (Gore-Felton, & Koopman, 2008), few studies have investigated the relationship between spiritual coping and health behaviors in this population. The health behaviors that are most relevant to long-term survival with and preventing the transmission of HIV include strict adherence to medication regimens, practicing safer sex, and refraining from substance use. Since coping with stress and adversity are crucial to maintaining health and reliably performing these health behaviors in PWH and since spiritual coping is a potentially powerful coping method, this thesis aims to determine whether the use of spiritual coping is related to performing health behaviors in PWH.

Spirituality can be a source of coping strategies for those facing adversity (Hathaway & Pargament, 1990). People who use religion as a tool to cope with negative life events have psychological and emotional benefits compared to people who do not (Burker, Evon, Sedway, & Egan, 2005; Kirkpatrick & Shaver, 1992; Pargament, Magyar, Benore, & Mahoney, 2005). Pargament, Kennell, Hathaway, Grevengoed, Newman, and Jones, (1988) operationalized spiritual coping as the use of spirituality to solve various problems. They developed the Religious Problem-Solving Scale to identify three types of spiritual coping styles: self-directing, deferring, and collaborative. People who see themselves as independent from God when coping and solving problems use a self-directing coping style. People who believe they are waiting for God to offer solutions to their problems use a deferring coping style. People who feel they work together with God to solve problems use a collaborative coping style.

Spirituality has an impact on patients’ ability to cope with illness. For many individuals, spiritual beliefs and practices provide a source of comfort, supply a font of wisdom to help make sense of what seems otherwise senseless, and prescribe a ritual pathway for addressing the basic spiritual questions of meaning, value, and relationship (Sulmasy, 2009). Spirituality provides growth in several relationship
fields. In the intrapersonal field (with himself), brings hope, altruism and idealism, purpose for life and for suffering. In the interpersonal field (with others) brings tolerance, unit, and the sense of belonging to a group. In the transpersonal field (with a supreme power), awakes the unconditional love, worship and the belief of not being alone (McColl et al, 2000). Spiritual beliefs may assist people in providing a sense of control in understanding, coping with and interpreting events or experiences. Previous studies indicate that individuals who hold religious beliefs allow an individual to reduce the stressful reactions to events that they deem to be uncontrollable by reframing or reinterpreting those events, possibly gaining a new meaning and understanding from them (McCulloch, 2009). It is important to have meaning or purpose in life. This sense of meaning is diminished by an illness. This loss and its associated rediscovery were central aspects of both depression and spirituality. Spirituality may provide such a sense of meaning through its emphasis on liturgy, worship and prayer found in the major religious traditions (Dein, 2009). Adverse life events may be appraised in a different way. Religion provides a meaning context in which adversity can be understood.

Spirituality has also been recognized as an important coping strategy among those dealing with HIV/AIDS disease progression, largely due to the existential crisis that results from declining health and approaching mortality. The strong emphasis that is often placed on spirituality in the face of illness and death has often been explained by (a) the hope that spirituality instils due to the emphasis that is placed on prototypical healing themes, (b) the relief that spirituality offers about the uncertainty of death, and (c) the ease spirituality offers from emotional burden by eliciting emotion-regulating cognitive processes (Seigal & Schrimshaw, 2002). It should not be surprising however, that spirituality has also been with negative HIV/AIDS outcomes, including stigma and social exclusion, resulting largely from etiological beliefs concerning divine retribution and punishment.

People vary in their response to loss (Wendy, Lichtenthal, Cruess, & Holly, 2004; George, 2004) just as they differ in how they cope with stress in general (Carver, Michael, & Jagdish, 1989). As one important subset of coping responses, positive religious coping (PRC) has been conceptualized by Pargament, Smith, Koenig, and Perez as: “an expression of a sense of spirituality, a secure relationship with God, a belief that there is meaning to be found in life, and a sense of spiritual connectedness with others” (Pargament, Smith, Koenig, & Perez, 1998). Negative
relational coping (NRC), on the other hand, refers to “spiritual discontent, punishing God reappraisals, interpersonal religious discontent, demonic reappraisals (attributing the event to the work of the devil), and reappraisals of God’s power” (Pargament, Smith, Koenig, & Perez, 1998, p. 710). Importantly, (Hills, Paice, Cameron, & Shott, 2005) and (Pargament, Koenig, Tarakeshwar, & Hahn, 2001) found that it is commonplace for individuals to use both PRC and NRC at the same time, a phenomenon confirmed in more recent samples, as outlined below.

Aspects of spirituality may have a beneficial effect on a variety of health-related physiological mechanisms. In particular, spirituality’s emphasis on contentment, forgiveness, hope and love, may positively affect an individual’s physical wellbeing. Furthermore, spirituality may reduce feelings of negative emotions, such as anger, fear and revenge, reducing tension levels (McColl et al., 2000). Spirituality is a powerful tool for coping because elements of spirituality play crucial roles throughout the coping process (Pargament, 1997). Several study findings have highlighted the importance of spirituality in coping with HIV-related stressors (Tarakeshwar, Swank, Pargament, & Mahoney, 2005)) such as the loss of a loved one to AIDS (Richards, Acree, & Folkman, 1999), overcoming guilt and shame for engaging in risky behaviors (Kaldjian, Jekel, & Friedland, 1998), and finding a sense of purpose in life (Siegel & Schrimshaw, 2002). Higher levels of spirituality have also been related to long term survival with HIV (Barroso, 1999; Ironson & Kremer, 2009; Ironson, Stuetzle, & Fletcher, 2006). While there is research that examines the impact of spiritual coping on health outcomes, mental well-being, and quality of life in PWH (Gore-Felton, & Koopman, 2008), few studies have investigated the relationship between spiritual coping and health behaviors in this population. Since coping with spiritual distress is crucial to maintaining health in PLWHHA, this thesis aims to determine whether the use of spiritual coping is related to people living with HIV/AIDS.

However, the kind of spirituality (i.e., positive or negative) adopted by the patient may have a critical impact on the course of the disease. Ironson, Stuetzle, and Fletcher (2006) conducted a study in which 45% of participants reported an increase in positive spirituality following an HIV diagnosis. Heightened positive spirituality after an HIV diagnosis was a protective factor for physiological disease progression in HIV patients, compared to patients whose spirituality decreased following HIV diagnosis (Trevino, Pargament, Cotton, Leonard, Hahn, Caprini-Faigin, & Tsevat,
2010). On the other hand, negative aspects of spirituality such as spiritual struggle, anger at God, or viewing HIV as a sin are associated with poor medical compliance (Parsons, Cruise, Davenport, & Jones, 2006), and faster disease progression (Ironson, Stuetzle, & Fletcher, 2006; Trevino, Pargament, Cotton, Leonard, Hahn, Caprini-Faigin, & Tsevat, 2010). Therefore, the type of spiritual beliefs and practices will help determine if spirituality will be a protective or risk factor to the progression of HIV.

Previous findings indicate that PWH draw on their spirituality to help them cope with the stress of the illness (Trevino, Pargament, Cotton, Leonard, Hahn, Caprini-Faigin, & Tsevat, 2010). PWH have indicated that spirituality gives them hope, provides meaning to life, empowers them, fosters a feeling of connectedness both to their community and to a higher presence, creates a sense of peace, and ameliorates their suffering (Ironson, Solomon, Balbin, O’Cleirigh, George, Kumar, & Woods, 2002; Ironson, Stuetzle, & Fletcher, 2006; McCormick, Holder, Wetsel, & Cawthon, 2001; Park & Folkman, 1997; Tarakeshwar, Swank, Pargament, & Mahoney, 2001). Spirituality also influences the appraisal of stressors by influencing one’s perception of the stressful situation (Ironson & Kremer, 2010).

Previous findings have demonstrated that many PWH find turning to their spirituality to be an effective coping method (Coleman, Eller, Nokes, Bunch, Reynolds, Corless, & Seficik, 2006; Cotton, Tsevat, Szaflarski, Kudel, Sherman, Feinberg, & Holmes, 2006). Spirituality is also an efficacious method for coping with the HIV diagnosis itself. Ironson, Stuetzle, and Fletcher. (2006) found that 45% of PWH in their sample experienced an increase in spirituality and/or religiousness in the year following their HIV diagnosis while only 12% experienced a decrease in spirituality. For some, this increase actually transformed their spirituality and, in turn, their global belief system (Kremer & Ironson, 2009). Those who undergo such a spiritual transformation have improved health outcomes, including decreased viral load (Ironson & Kremer, 2009; Simoni, Frick, & Huang, 2006), increased CD4+ cell count, and decreased mortality (Ironson & Kremer, 2009).

A consistent with theory and empirical research on spiritual coping in adults (Pargament, Smith, Koenig, & Perez, 1998), youth with chronic illness use spiritual coping strategies (Cotton, Grossoehme, & McGrady, 2012; Pendleton, Cavalli, Pargament, & Nasr, 2002), and these strategies are strongly related to their behavioral and emotional functioning. Specifically, positive spiritual coping involves cognitive
strategies such as seeking comfort and strength from God or believing that God is strengthening the individual in the situation. Positive spiritual coping is associated with lower emotional distress in youth with asthma, cystic fibrosis, and diabetes (Reynolds, Guion, & Mrug, 2013; Shelton, Linfield, Carter, Morton, 2005). However, not all spiritual cognitions are helpful (Pargament, Smith, Koenig, & Perez, 1998). Some individuals also experience negative spiritual coping, including spiritual doubts or thoughts of being abandoned or punished by God. Negative spiritual coping predicts poorer quality of life and more emotional and behavioral problems in pediatric populations (Benore, Pargament, & Pendleton, 2008; Reynolds, Guion, & Mrug, 2013). The use of positive and negative spiritual coping dimensions is either positively correlated (Benore, Pargament, & Pendleton, 2008; Pargament, Smith, Koenig, & Perez, 1998), or unrelated (Reynolds, Guion, & Mrug, 2013) suggesting that patients may use both, either, or neither dimension of spiritual coping.

People often draw upon their spiritual belief systems in order to cope with adverse circumstances. Pargament, Smith, Koenig, and Perez (1998) identify two types of religious coping, namely positive religious coping and spiritual struggle (also referred to as negative religious coping). Positive religious coping involves actions that are directed at seeking an intimate relationship with God as well as the belief that there is a larger meaning to one's life. In contrast, spiritual struggle involves conflict, doubt and the questioning of one's faith, religious relationships and God (Pargament Smith, Koenig, & Perez, 1998). Whereas positive religious coping has been associated with positive psychological outcomes in people living with HIV, spiritual struggle has been associated with negative psychological outcomes (Trevino, Pargament, Cotton, Leonard, Hahn, Caprini-Faigin, & Tsevat, 2010); Note that religious coping can also have a social support element, as people using religious coping often go to religious meetings for fellowship with other believers, or seek religion-based counselling (Tarakeshwar, Khan, & Sikkima, 2006). Furthermore, religious coping has a strong meaning-focused element, (Kremer, Ironson, & Kaplan, 2009). Previous research suggests that religious coping is often used by people living with HIV (Barroso & Powell-Cope, 2000; Maman, Cathcart, Burkhardt, Omba, & Behets, 2009; Perry, Davis-Maye, & Onolemhemhen, 2007; Sorajjakool, 2006). It has been found that if organized religion did not provide the needed support, some people
living with HIV turned to a broader sense of spirituality, the appreciation of prayer and meditation, and belief in a deity (Barroso & Powell-Cope, 2000). Research conducted in sub-Saharan Africa has revealed that people living with HIV sometimes incorporate/take their traditional beliefs in ancestors into organized religious doctrine (Dageid & Duckert, 2008).

Studies on spirituality and mental health have looked at the mechanisms involved in spirituality, which may improve mental wellbeing. There is some evidence that positive coping styles can be very positive in terms of people’s mental health (McCulloch, 2007). Aspects of spirituality may have a beneficial effect on a variety of health-related physiological mechanisms. In particular, spirituality’s emphasis on contentment, forgiveness, hope and love, may positively affect an individual’s physical wellbeing. Furthermore, spirituality may reduce feelings of negative emotions, such as anger, fear and revenge, reducing tension levels (McCulloch, 2007).

1.10 Significance of the study

While results of previous studies indicate the importance of spirituality/religion among individuals with HIV/AIDS has been limited by small samples, lack of coherent measures of spirituality, and cross-section designs. In the present study, we will examine the role of spirituality in terms of the assessment of spiritual distress and spiritual coping. A useful technique that will be used to explore the multidimensional aspects of the constructs of spiritual distress and spiritual coping is factor analysis.

The present study is need for various reasons for HIV/AIDS people. The finding of present study would add great values, theoretical expansion, medical intervention and spiritual beliefs system. In addition, the finding of the present study will be more effective for people living with HIV/AIDS and their families.

Coping is known as a continuously varying process that involves changing in the relationship between the person and the stressful experiences/situation. The health behaviours that are most relevant to long-term survival with and preventing the transmission of HIV include strict adherence to medication regimens, practicing safer sex, and refraining from substance use. Since spiritual coping with spiritual distress are crucial to maintaining health, in this regard, the present investigator has made an attempt to explore coping strategies used by people living with HIV.
1.11 Conceptual and Operational Definitions of the Variables

HIV/AIDS

**Conceptual definition:** HIV is referred as “Modern pandemic” which is a fatal disease caused by retro virus known as ‘Human Immune Deficiency Virus’. These break down body’s immune system and are likely to develop life threatening opportunistic infections, neurological disorder and unusual malignancies (Park, 2009).

AIDS is short for acquired immune deficiency syndrome. It is the most advanced stage of HIV disease. AIDS is defined as a “syndrome of opportunistic infections and certain cancers” which is acquired as the individual’s immune system becomes progressively less able to protect itself due to the HIV-infection (Van Dyk, 2008).

**Operational definition:** It is estimated that there is one HIV infection related death in every 15 minute, one HIV diagnose in every nine minute and someone infected with HIV in every 13 minute (McEnany, Huges, & Lee, 1995).

**Stages of HIV**

Centers for Disease Control and Prevention, (CDC, 2014) system classifies HIV infections based on CD4 count and clinical symptoms, and describes the infection in five stages or groups. Those whose age is greater than six years are included (Centers for Disease Control and Prevention, (CDC, 2014):

- Stage 0: the time between a negative or indeterminate HIV test followed less than 180 days by a positive test (CDC, 2014).
- Stage 1: CD4 count ≥ 500 cells/µl and no AIDS defining conditions (CDC, 2014).
- Stage 2: CD4 count 200 to 500 cells/µl and no AIDS defining conditions (CDC, 2014).
- Stage 3: CD4 count ≤ 200 cells/µl or AIDS defining conditions (CDC, 2014).

Spiritual distress

**Conceptual definition:** Spiritual distress is defined by the North American Nursing Diagnosis Association (NANDA) as “the disruption in the life principle that pervades a person’s entire being and that integrates and transcends one’s biological and psychosocial nature” (2001).
Chapter 1: Introduction

Operational definition: The term “Spiritual Distress” is conceptualized as a state of emotional suffering characterized by feeling of alienation, meaninglessness, hopelessness and spiritual loss which affect HIV/AIDS people level of functioning.

Spiritual coping

Conceptual definition: Spiritual coping is defined as “a set of cognitive-behavioral skills which focus on the connection to a higher presence that aid in meaning making, positive reframing, self-empowerment, and growth on a personal and/or spiritual level” (Kremer & Ironson, 2009).

Operational definition: Spiritual coping includes a set of spiritual practices, God’s support, spiritual resources or spiritual transformation that one associates with cultivating spirituality to cope with spiritual distress.

1.12 Research Objectives:

1. To standardize and determine the psychometric characteristics of Spiritual Distress Scale.

2. To standardize and determine the psychometric characteristics of Spiritual Coping Scale.

3. To examine the influence of gender, stages, and interaction between gender and stages among people living with HIV/AIDS on spiritual distress.

4. To examine the influence of gender, stages, and interaction between gender and stages among people living with HIV/AIDS on dimensions of spiritual distress, namely, feeling of alienation, meaninglessness, hopelessness and spiritual loss.

5. To examine the influence of gender, stages, and interaction between gender and stages among people living with HIV/AIDS on spiritual coping.

6. To examine the influence of gender, stages, and interaction between gender and stages among people living with HIV/AIDS on dimensions of spiritual coping, namely, spiritual practices, God’s support, spiritual resource and spiritual transformation.
Chapter 1: Introduction

1.13 Hypotheses:

1. There will not be influence of gender, stages, and interaction between gender and stages among people living with HIV/AIDS on spiritual distress.

2. There will not be influence of gender, stages, and interaction between gender and stages among people living with HIV/AIDS on dimensions of spiritual distress, namely, feeling of alienation, meaninglessness, hopelessness and spiritual loss.

3. There will not be influence of gender, stages, and interaction between gender and stages among people living with HIV/AIDS on spiritual coping.

4. There will not be influence of gender, stages, and interaction between gender and stages among people living with HIV/AIDS on dimensions of spiritual coping, namely, spiritual practices, God’s support, spiritual resource and spiritual transformation.
Chapter 1: Introduction

1.14 Conceptual Framework

Spirituality provides an important function of helping people to find meaning and purpose in their lives. This study creates a conceptual framework for the assessment of spiritual distress and spiritual coping in HIV/AIDS people. Assessing spiritual distress is one of the competencies for psychologists.

**Spiritual Distress**
- Feeling of Alienation
- Meaninglessness
- Hopelessness
- Spiritual Loss

**Spiritual Coping**
- Spiritual practice
- God’s Support
- Spiritual Resource
- Spiritual Transformation

HIV/AIDS