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# FOCUS

## A Guide to AIDS Research and Counseling

## The Place of Religion and Spirituality in HIV Counseling

Robert H. Hopcke, MFT

After two weeks of extraordinary anxiety, a client awaiting the results of his HIV test comes into our therapy session enormously relieved at his HIV-negative result. In passing he says, "You know, I don't even believe in God anymore, but in the past week, I found myself praying that he would make sure I don't die. I even went to a Catholic church and lit a candle—and I was raised Southern Baptist!"

A female client with a history of drug and alcohol use gets into recovery following an HIV-positive test result. After attending a couple 12-step meetings, she is conflicted: "I don't know about that 'higher power' stuff. I'm a very spiritual person but I'm not religious."

A long-term survivor of HIV has a relationship with a community of people who believe that following the prescribed practices of their spiritual teacher can cure AIDS, cancer, and diabetes. The client is exploring the possibility of selling his home, giving the proceeds to the community, and moving to the community's retreat center. "I've come to believe that I can be cured by meditation and right living. Miracles do happen."

These vignettes share the common theme of spirituality and religion, and for some clinicians, the faith-related aspects of a client's life can sometimes be a source of discomfort or confusion. Before the advent of modern psychology, people facing the challenges of life and death sought guidance from spiritual teachers within their religious communities—priests, lamas, imams, ministers, medicine women—and the process of healing body, mind, and spirit proceeded within the context of a coherent religious practice.

Today, professional counseling, with its empirically-based techniques and theoretical models, makes little room for unverifiable or subjective phenomena such as religious beliefs or spiritual experience. Psychotherapy—literally "soul healing"—is now largely a secular enterprise, and many otherwise highly competent professionals are ill-equipped to accommodate explicitly religious language and spiritual exploration. This article suggests ways of thinking about and addressing religious issues in order to enable counselors to talk directly about the faith-based aspects of their clients' lives.

### What Is Religion?

To begin, it is important to have working definitions for "religion" or "spirituality." Those proposed by James Fowler, the author of *Stages of Faith*, are clear and useful.<sup>1</sup> Fowler sees spirituality and religion as two sides of the same experience: "spirituality" is the inward, individual experience of the transcendent, and "religion" is any external, collective manifestation of that inner experience.

Further, any inward spiritual experience, for example, of the "Divine," has an external manifestation in a religious practice. That ritual or action, however, may not always be part of a larger community, group, or institution: it might be attending Mass or sitting "zazen" (a Zen Buddhist meditative practice) in the presence of others, or it might be simply retiring to a solitary place to welcome the rising of the solstice moon.

Bridging the false dichotomy between religion and spirituality can help counselors work more fully and comfortably with their clients. When an inner spiritual experience spontaneously presents itself in a session—for example, prayers to a God the client professes not to believe in or the transformative hope of being miraculously healed of AIDS—being alert to an external religious manifestation of this experience can lead to a fuller exploration and affirmation of the

# Editorial: The Only Reality that Counts

Robert Marks, Editor

It is hard to imagine counseling people with concerns about HIV, many of whom are confronting fundamental issues of illness, death, and sex, without being prepared to address the role of religion and spirituality in their lives. Yet, as Robert Hopcke suggests in this issue of *FOCUS*, explicit discussion of religion and spirituality remains difficult for many therapists.

The overlaps are obvious: sex is regulated more by religious institutions than legal ones, and laws related to sex and sexuality have evolved from religious doctrine. Illness and death are inextricably linked to conceptions of an afterlife. The faith that underlies religious practice often relates to a higher power and the belief that that power will influence events in this life. As Hopcke implies, it is inevitable that discussions of topics ranging from condom use and homosexuality to HIV treatment will touch on religious or spiritual convictions too deep to be traversed only by inquiries such as “How does that make you feel?” and then set aside.

Religious and spiritual conceptions are no different from any other influence on a person’s worldview, no different ultimately from his or her psychological or physical state. Faith, in particular, which rarely can be altered by “logic,” seems more akin to emotion than to philosophy. A therapist would never consider responding to a client’s emotion by gingerly avoiding further discussion of it. To the extent that religion enters therapy, client-centered counseling demands that it be honored and explored, challenged to the extent that it contradicts a client’s other stated needs or desires and affirmed to the extent that it does not.

Existential-phenomenological therapy, which, according to Martin Milton in this issue of *FOCUS*, treats everything as an “interpreted reality,” may offer among the most sensible of approaches for exploring religion and spirituality. This is ironic, since in its assertion of subjectivity, existential-phenomenological therapy could be interpreted as counter-

ing any religious doctrine: individual religions often conceive of themselves as absolute. But the subjectivity of existential-phenomenological therapy may also free counselors from the tyranny of their own beliefs, better enabling them to accommodate and prioritize the client’s beliefs over their own.

Existentialism is at its essence about meeting a person where his or her reality is. This is not to say that many psychotherapeutic approaches are not about meeting clients where they are. But it does suggest that avoiding a client’s religion or spirituality is no different from avoiding any other uncomfortable aspect of that client’s reality: his or her personality, behavior, demeanor, political beliefs, sexual orientation, race, or gender.

Client-centered counseling skills, especially as they relate to crossing cultures, are particularly useful in this context. Another way of thinking about it is that in therapy, the client’s reality is the only one that counts. The therapist’s reality is a tool the client uses to refine his or her own subjective interpretation in order to find affirmative ways of responding to his or her distress.

client’s experience. Likewise, when a client describes actions with outward religious significance—anything from joining or leaving a religious community or enduring involuntary expulsion from the clergy to lighting a candle—it may be appropriate to concentrate on the inward spiritual experience in order to help make this subjective part of the experience conscious.

## Beneath the Myth of Secularism

Counselors may also be impeded from approaching existential questions by the myth of the “secular” society. As Diana Eck points out in her recent book, *The New Religious America*, the United States contains a galaxy of churches, religious denominations, and spiritual groups that run the gamut from traditional to untraditional.<sup>2</sup> People in the United States are among the most religious in the world, with a vast majority of the population con-

sistently reporting a belief in God and weekly attendance at religious services.

Beneath the myth of secularism, therefore, the religious landscape of the United States reflects what Carl Jung called the “religious instinct” of the psyche, our natural search for something beyond ourselves that has always been a part of the human experience.<sup>3</sup> For this reason alone, it makes sense that a life-threatening illness would bring up questions that are at the core of the religious experience. What is the nature of existence? Where did I come from and, when I die, where am I going? What is my purpose here on earth and how do I fulfill it before the end of my life?

Theologian Paul Tillich said that religious faith, our “god values,” are always the expression of what each person holds to be of “ultimate concern.”<sup>4</sup> Because HIV disease forces a confrontation with mortality, the question of what a person values most,

or to use religious language, the “heart of our faith,” is a natural one to explore.

But the ultimate concerns raised by HIV are not the only reason that religious and spiritual questions come up within HIV-related counseling. For the two populations most affected by HIV in the United States, counseling—secular as it might be—is often the only safe, nonjudgmental place to begin

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wondering what an authentic spirituality or personally meaningful religious practice might be. Gay and bisexual men have often been alienated by the explicit homophobia of so many traditional religious institutions. Likewise, people engaged in drug and alcohol use are frequently judged as “immoral” or “sinful” by religious standards and, thus, may have to grapple with what “God” means to them, particularly in the context of 12-step models of recovery that emphasize a relationship to a “higher power.” The failure of many religious institutions to acknowledge people in these populations has also added to the reticence of so many counselors working with

HIV to help clients confront religious and spiritual dilemmas.

If counselors can manage to be nonjudgmental about sexual practices, ethnic differences, and class background, however, surely we can remain neutral enough to ask clients resembling the ones in the vignettes at the beginning of this article questions such as: “When you were praying to God, what image did you have?” “What is the difference for you between being spiritual and being religious?” “Can you tell me a little about how it feels to think about making such an enormous commitment to the ashram?”

### **Spiritual Development and Stages of Faith**

Religious faith is not a binary phenomenon: it is much more nuanced than merely believing or not believing in God. Beginning with the work of William James<sup>5</sup> and Carl Jung,<sup>5</sup> and more recently with the theories of Lawrence Kohlberg, Carol Gilligan, and James Fowler, it has become clear

that an individual’s religious, spiritual, and moral development proceeds in stages over the course of a lifetime. Fowler proposes a model of faith development that progresses in distinct stages throughout the life cycle.<sup>1</sup> The first two stages range roughly from age 3 to age 11. In Stage 1, a child has an “intuitive-projective” faith in which God is projected from the child’s imagination onto the world. A more “mythic-literal” faith emerges during Stage 2, around age 7, during which religious stories are usually understood literally and offer a sense of comfort for knowing who one is in the world and in the family.

Stage 3, a “synthetic-conventional” faith, begins most commonly in the teenage years and reflects a teenager’s concern with social acceptance and movement into a larger group beyond the family of origin. The religious faith of individuals at this stage largely relates to adherence to the moral, religious, and practical rules as set forth by selected authorities. Such individuals tend to identify themselves and others in terms of their religious group, applying an “in-group versus out-group” paradigm.

Fowler believes, however, that over time, the conflicts and complexities of life sometimes move individuals from “conventional” faith into Stage 4, “individua-tive-reflective faith.” As contradictions emerge between ideal theological teachings and real life and the practice of these teachings, or as a person’s incapacity to live up to such ideals becomes clear, people begin to examine their own experience. In response, they sometimes break away from previous religious commitments and begin seeking what is true for them as individuals independent of religious teachings or community regulations.

After what may well be an extended period of religious and spiritual “seeking,” sometimes the “seeker” progresses out of this intensive personal process of discernment into a more integrated system, which Fowler calls Stage 5, “conjunctive faith.” The individual no longer insists on a single fixed truth for him or herself, or for others, and develops a profound appreciation of the diversity of experience and belief across traditions. The result is a stable but varied religious practice, derived from a number of sources and based on the evolution of the individual’s experiences and beliefs. During Stage 5, people begin to be compelled by broader and more abstract religious issues, for example, a concern for justice, compassion for all sentient beings, peace, and inclusiveness across culture and tradition.

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### Applying a Developmental Perspective

Fowler's developmental perspective provides a cogent model for understanding at least two typical situations that consistently arise in HIV-related counseling. First, individuals who have not been raised in specific faith traditions begin to ask themselves, for the first time as they confront HIV, urgent and unavoidably religious and spiritual questions. Fowler's model provides a shape for the process that may unfold as such clients move forward. Initially they might adhere to one model, one group, or one tradition—for example, the 12-step program's Big Book or Zen practice—as an unswerving path toward transcending HIV. Then, in the course of longer-term survival, these clients might move from such initially rigid adherence toward a more discriminating spirituality and even, over time, toward a more inclusive set of attitudes and religious practices. Recognizing the broader outlines of such a process helps keep the conversation about spirituality and religion alive as it manifests in counseling over time and in varied ways.

Second, individuals facing HIV may seek to return to a Stage 3, conventional faith, in response to trauma, for example, the news of seroconversion or a formal AIDS diagnosis. Such individuals may have been comfortable “seeking,” within a Stage 4 process of “individuation and reflection,” but in the context of anxiety, depression, or terror, may take comfort by joining an “in-group” and adhering to prescribed rituals or actions. Fowler's model suggests that such reactive flights into “conventional faith” may be a step backward; in response, counselors might want to help these individuals find a way to continue the natural vector of their religious development forward.

On the other hand, an individual raised in a specific religious tradition and with a

conventional spirituality may be catapulted out of Stage 3 by the trauma of HIV. Given this different starting point, what may initially look like the reactive adoption of spiritual practices or religious attitudes might actually signify a progression into the seeking of Stage 4. Counseling might support the exploration of an individual who, raised as a Southern Baptist or as a secular humanist, may take a serious look into what Roman Catholicism, Zen Buddhism, or Narcotics Anonymous has to offer.

Ultimately, Fowler's developmental perspective leads a clinician to ask: are the religious and spiritual crises engendered by HIV a progression or a regression, a movement forward or a movement back? Rather than a binary or dichotomized view of “belief” and “unbelief,” this model can form a strong foundation for making such judgments in ways that are both psychologically astute and theologically neutral.

### Conclusion

It is difficult to imagine counseling people with HIV-related concerns, many of whom are confronting fundamental issues of illness, death, and sexuality, without being prepared to address the role of religion and spirituality in their lives. Remaining aware of the extraordinary religious diversity of the United States and appreciating the complexities of faith development enables clinicians to explore not only the religious and spiritual dimension of HIV in the lives of their clients but also other aspects of the self that are influenced by religion and spirituality. Comfort in speaking in explicitly religious or spiritual language within the psychotherapeutic relationship provides a space for yet another dimension of healing to take place, the source of which is indeed greater than the therapist or any psychological theory.

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## Clearinghouse: Religion and HIV Counseling

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# Existential Psychotherapy and HIV

Martin Milton, PsychD

Existentialism, well known as a branch of philosophy, can be applied as “existential-phenomenological” psychotherapy. Since it directly engages with the struggles of life as a way of facilitating personal values and self-empowerment,<sup>1</sup> existential-phenomenological psychotherapy has promise for helping clients work through the complications of living with HIV.

Existentialism describes a distinctively human mode of being and assists clients by helping them clarify what it means to be alive.<sup>1</sup> One theme within existentialism is to see the challenge of living as an attempt to find a balance between what is possible and what is necessary in a person’s life, and, in the process, to experience both authentic and inauthentic ways of being.

“Phenomenology” refers to the study of phenomena—the appearance of things—as they present to a person’s consciousness.<sup>2</sup> The “reality” that each person experiences is the result of an interaction between the raw matter of the physical world—in the context of HIV, everything from physical illness to acts of prejudice or marginalization—and that person’s consciousness of this raw matter. As such, “reality” is open to many meanings, and each individual can achieve only an “interpreted” reality.<sup>2</sup> This may seem overwhelming, but in fact, exploring and understanding this individual reality can assist each person in opening up to the potential meanings of his or her experience.

## Central Concepts of Existentialism

One branch of existentialism finds its roots in the work of the French philosopher, Jean-Paul Sartre, who contends that humans have no fixed essence: we exist first and, in

the process of existence, we have to create ourselves.<sup>3</sup> In order to escape from the anxiety of this uncertainty, however, people marshal a kind of self-deception that enables them to act as if they were something definite and “fixed.” Sartre terms this “bad faith.”

For example, a person’s experience of life and him or herself may change when he or she becomes labeled as a “patient.” Some will be dominated by this conception of self, revert to “bad faith,” and adopt the life of a patient, while others will incorporate the fact of illness without letting it overwhelm the broader experience of their lives.

Sartre recognized that through their actions, individuals choose what they will become, and this choice, in turn, determines a person’s possibilities for the future.<sup>3</sup> It is important to note that this choice refers to development of the sense of self; there is no Sartrean theory suggesting that if I decide I want to be president or clever or African American that I will inevitably attain these goals. Existential psychotherapists recognize that circumstances may influence or limit an individual’s possibilities. Once a person becomes HIV-positive, he or she has no choice about being infected, but for some people, seroconversion leads to depression, for others, it provokes anxiety, and for still others, it triggers a broad reflection on life, so much so that some describe this process following seroconversion as a blessing.

Another philosopher whose work is of great significance to existentialism is Martin Heidegger. One of his central concerns is the nature of “Dasein,” roughly translated from German as “being in the world.” This concept suggests that the essence of being human is to relate: to self, to others, and to the wider world of things and values.

Heidegger also introduces the notions of “authenticity” and “inauthenticity,” which many interpret as a dichotomous view of good and bad, or healthy and unhealthy. In

perspective. *Journal of Association of Nurses in AIDS Care*. 2001; 12(3): 58–65.

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See also references cited in articles in this issue.

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fact, Heidegger sees authenticity and inauthenticity as inevitable human responses.<sup>4</sup> Authenticity includes a recognition of our ultimate “being-towards-death” and other limitations, for example, in terms of HIV, illness, embodiment, and stigma. Inauthenticity, a response to the anxiety of these realizations, is marked by a resignation to convention, conformity, and duty to what a person imagines other people expect of him or her.<sup>5</sup>

While Heidegger’s work implies that we benefit from the authentic stance of knowing our capacities, it also recognizes that this is difficult. Inevitably, life leads to the failure to be open to events and to ourselves; at those times people revert to inauthenticity, to something akin to Sartre’s bad faith. The capacity for inauthenticity or bad faith, however, is simply an aspect of being. People naturally find themselves being carried along by consensus. In the context of HIV, for example, many would not question the potential value of taking medication, however, taking medication because everyone says you should indicates inauthenticity. Taking medication because it is personally meaningful is an indication of authenticity.

## Undertaking Psychotherapy

Existential-phenomenological psychotherapy is a philosophical approach to therapy rather than a technique, per se. It concerns itself with the ways an individual negotiates, or fails to negotiate, the givens of existence—death, anxiety, meaninglessness, isolation, choice, responsibility—and how interpretations of these aspects shape an individual’s sense of him or herself and the world. As such, existential psychotherapy conceives of all forms of human dilemma and suffering as problems that are fundamentally about “being in the world.”

When people, life, and therapy are understood from the perspective of the client’s frame of reference, the therapeutic encounter can be an invitation for the client to confront and clarify the meanings of his or her anxiety, rather than attempt to reduce or eliminate them. Indeed, to attempt to “cure” people of anxiety would involve curing them of life itself.<sup>5</sup> The existential-phenomenological therapeutic process assists the client in making explicit those beliefs and assumptions that have remained implicit and unacknowledged in the development and maintenance of their difficulties.<sup>6,7</sup>

This, of course, means that therapy places less stress on objective truth and more on the client’s individual meanings. The approach is skeptical of notions of disorder and pathology, using terms such as “dilemma” and “difficulty” in order to characterize the struggles

that people experience without ascribing a psychiatric or psychological foundation or diagnosis. Therapy attends to the struggle within the client’s life and the ways in which his or her sense of self or living has become confusing, distressing, or fragmented.

In order to facilitate the exploration of existence, the existential-phenomenological method derives from three basic principles that are flexibly applied.<sup>2,8</sup> “Epoche” refers to a setting aside of the therapist’s initial assumptions about the therapeutic encounter. For example, the therapist accepts that he or she does not know how a particular client understands health and may set aside the process of correcting inaccurate medical knowledge in favor, at least initially, of understanding the ways in which the client’s beliefs may facilitate a sense of self or way of understanding the world.

Second, employing “description,” the therapist prioritizes the direct relationship clients have with their experiences by facilitating the client’s narrative of experiences and beliefs. In doing so, the process focuses, at least temporarily, on the raw experiential data of the body and emotion to uncover meaning. Third, “horizontalization” discourages ranking the elements of a client’s story, enabling therapists to perceive, at least initially, each element as having equal value.<sup>2</sup>

## Conclusion

For many people, the dilemmas raised by living with HIV or avoiding infection cut to the core of their beings. Existential-phenomenological therapy offers a way of approaching the therapeutic dialogue that directly addresses the philosophical and psychological questions of the meaning of being alive and the subjectivity of experience. Existential therapy may not be right for every client, but it is a particularly useful for those who are uncomfortable with the labeling and compartmentalizing of a medical approach and who seek to understand themselves in light of the social context that HIV creates.

## Comments and Submissions

We invite readers to send letters responding to articles published in *FOCUS* or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals. Send correspondence to [rmarks@itsa.ucsf.edu](mailto:rmarks@itsa.ucsf.edu) or to Editor, *FOCUS*, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.

## Recent Reports

### Spiritual Therapy for Substance Users

Marcotte D, Margolin A, Avants K. Addressing the spiritual needs of a drug user living with human immunodeficiency virus: A case study. *Journal of Alternative and Complementary Medicine*. 2003; 9(1): 169–175. (Yale University.)

A structured spiritual component of substance abuse treatment can increase a person's feelings of hope and sense of control over his or her life, according to a case study detailing Spiritual Self-Schema Therapy, a spiritual approach to recovery.

The goal of Spiritual Self-Schema Therapy (3-S) is to achieve a shift from a negative, defeated sense of self to one that is positive and hopeful. This seven-treatment therapy process focuses on acknowledging the distinctions between the “addict” self—characterized by despair, injection drug use, and high-risk HIV-related behaviors—and the “spiritual” self—characterized by honesty, hope, responsibility, and self-care. By identifying these two “selves,” the subject can begin to empower him or herself by making conscious choices about which “self” he or she wants to become.

Upon beginning 3-S therapy, subjects assess the degree to which they thought, felt, and behaved like the addict or the spiritual self during the preceding week. They then engage in techniques to activate the spiritual self and deactivate the addict self. For example, participants maintain a daily log in which they record events, feelings, and thoughts that have contributed to their current sense of self. Subjects also use visualization strategies to strengthen the spiritual self and to manage drug cravings.

“Pauline,” a White, 37-year-old woman, had an 18-year history of injection cocaine and heroin use. Upon the beginning of treatment, Pauline described herself as a disaffected, non-practicing Catholic. Spirituality had recently emerged as an important factor in her life, but she was unclear where to turn for spiritual guidance.

Pauline first listed attributes of each “self,” then participated in therapy sessions focused on strategies to deactivate the addict self and to activate the spiritual self. Pauline engaged in a variety of spiritual

activities, including journal writing, prayers of petition, and participation in Roman Catholic traditions, thereby reinforcing a personal sense of spirituality.

These processes served to increase Pauline's desire to change and to realize the shift from her addict self to her spiritual self. Prior to treatment, Pauline viewed the addict self as the inevitable outcome; following therapy, she felt a sense of control over which self she chose to express. Upon the end of treatment, Pauline had experienced four weeks of sobriety and described new feelings of hope and strength. Additionally, Pauline had increased her sense of self-awareness, had begun to resolve past regrets, was more attentive to her health, and was better able to focus on the needs of others as well as herself.

### Religion and Risk in African American Girls

McCree DH, Wingood GM, DiClemente R, et al. Religiosity and risky sexual behavior in African-American adolescent females. *Journal of Adolescent Health*. 2003; 33(1): 2–8. (Emory University; and University of Alabama.)

Female African American adolescents with higher levels of religiosity report engaging in fewer sexual risk behaviors than less religious subjects, according to a large study in the southern United States.

Between December 1996 and April 1999, researchers screened female adolescents who attended medical clinics, health department clinics, and school health classes to determine eligibility for an STD/HIV prevention trial. Subjects had to be between the ages of 14 and 18, and had to have willingly had vaginal intercourse with a male partner at least once in the prior six months. Of the 1,130 subjects screened, 522 met eligibility criteria and chose to participate in the study. Subjects completed self-administered questionnaires and participated in structured one-on-one interviews on sexual behaviors led by a female African American facilitator.

Researchers determined level of religiosity based on participants' answers to questions about how often they attended religious or spiritual services, prayed or meditated, discussed religious or spiritual concerns with others, and talked with religious or spiritual leaders. Participants also reported information about their sexual histories, including the age they first willingly had sex, frequency of sexual communication, condom use, self-efficacy, attitudes about condoms, and their ability to refuse unsafe sex.

Compared to subjects with lower religiosity scores, subjects with higher religiosity scores were 2.3 times more likely to have higher self-efficacy to communicate with new partners about sex; 2.5 times more likely to have communicated with their partners about sexually transmitted disease, HIV, and pregnancy prevention; and 2.1 times more

**Black, female adolescents with higher levels of religiosity engaged in fewer risk behaviors.**

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likely to have higher self-efficacy to refuse an unsafe sexual encounter. Subjects with greater religious involvement also had more positive attitudes toward condom use, and were 1.5 times more likely to have initiated sex at a later age than less religious subjects.

### Religiousness in Long-Term Survivors

Ironson G, Solomon G, Balbin EG, et al. The Ironson-Woods spirituality/religiousness index is associated with long survival, health behaviors, less distress, and low cortisol in people with HIV/AIDS. *Annals of Behavioral Medicine*. 2002; 24(1): 34–48. (University of Miami; University of California, Los Angeles; and National Institute for Healthcare Research.)

Spirituality and religiousness are associated with long-term survival among people with AIDS, according to a Miami study.

Researchers compared 79 subjects classified as long-term survivors of AIDS with 200 subjects defined as the HIV-positive comparison group. They used the Centers for Disease Control and Prevention definition of long-term survival: surviving twice the median survival time expected for people with CDC-defined AIDS. Among the participants in this group, those who used HIV antiviral therapy had to have waited at least four years past an opportunistic infection or neoplasm before starting treatment. Subjects in the comparison group had to have CD4+ counts between 150 and 500 at the beginning of the study and could not ever have had an opportunistic infection.

There were no significant differences between the two samples in terms of gender or ethnicity. The samples were approximately 75 percent male, 25 percent female, 33 percent African American, and slightly less than 33 percent each White and Latino. The long-term survivor group was significantly older: the average long-term survivor subject was 40 years old, compared to 38 for comparison subjects. Long-term survivors also had significantly more education, were more likely to be on disability and less likely to be working full-time, and had lower income than comparison subjects.

Among both samples, 50 percent of subjects were infected through homosexual sex, 33 percent by heterosexual sex, and five percent through injection drug use. Acquisition by injection drug use was underrepresented because the participation criteria excluded subjects with present substance dependence or use in the prior month.

Participants filled out questionnaires about both public and private religiousness and spirituality, psychosocial issues such as hopelessness and social support, and behaviors such as safe sex, cigarette use, alcohol consumption, and medication

adherence. Subjects also provided urine samples to measure cortisol levels as an indication of physiological distress.

Roughly 50 percent of the overall sample identified as spiritual but not religious; 33 percent identified as both spiritual and religious; 8 percent identified as religious but not spiritual; and 10 percent identified as neither. Long-term survivors were significantly more likely to have indicated a greater sense of peace, faith in God, religious behavior, and a compassionate view of others. Long-term survival was positively associated with frequency of prayer and negatively associated with judgmental attitude. Higher levels of religiousness and spirituality were also significantly correlated with less distress, more hope, greater social support, more health-related behaviors, more acts of helping others, and lower cortisol levels.

Despite these associations, it is necessary to question whether people who are more spiritual or religious are more likely to become long-term survivors or whether people become more spiritual or religious when they get sick. Twenty-two of the comparison subjects—who initially had not had any past opportunistic infections—developed an infection over the course of the four-year study. There was no significant change in spirituality or religiousness in any of these subjects from initial assessment to the final assessment, indicating that it is unlikely that higher levels of spirituality or religiousness among long-term subjects were due to changes in participants after they got sick.

### Next Issue

Over the past 10 years, several studies have found a robust relationship between sexual compulsivity and HIV-related risk. In the July issue of *FOCUS*, **Frederick Muench, MA**, former Project Director of the Assessment and Psychopharmacological Treatment of Sexual Compulsivity in MSM study at Mount Sinai School of Medicine, and **Jeffrey T. Parsons, PhD**, Associate Professor of Psychology at Hunter College in New York and Co-Director of the Center for HIV/AIDS Educational Studies and Training (CHEST), define sexual compulsivity, its assessment, and treatment, and its relationship to HIV transmission.

Also in the July issue, **Lisa Loeb, MPH**, Research Manager at the UCSF AIDS Health Project, reviews the literature on the correlations between impotence medications such as Viagra and HIV-related risk.



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