Religion and spirituality can affect the attitudes, beliefs, and behaviors that increase or decrease a person’s HIV risk. To help clients make and sustain risk behavior change, HIV test counselors must be able to assess the role of these factors in decision making. This issue of the FOCUS Supplement explores the influence of religion and spirituality on clients’ HIV risk behaviors.

“Religion” usually denotes a system of beliefs explaining the nature or purpose of life, some aspect or understanding of creation or existence, and how people should behave in the world. It often includes the concept of a deity or some other unifying principle, which may include concepts, goals, or ideals that define the group vision as a whole. Some religions have a definitive written or oral text, such as the Christian Bible or the Islamic Koran, which some believers take literally while others view as being open to interpretation.

“Spirituality” is a broader term that refers to matters outside the physical realm of nature. A person’s sense of spirituality can include religious beliefs, but it may also represent a set of personal beliefs that do not belong to an organized religion and may or may not entail engaging in rites and practices that emphasize “the spirit.” Some people view spirituality as an acknowledgment of a level of existence that is neither physical nor mental, but instead represents a third area of reality that needs care and nurturing as much as the physical and mental aspects.

There are hundreds of belief systems throughout the world, from Advaita Vedanta, a classic salvation philosophy rooted in India,¹ to Scientology, which is rooted in the United States in this century.

HIV test counselors need not be experts on religion, but they do need to use their counseling skills to evaluate the relevance of a client’s religious or spiritual beliefs to HIV risk-taking behaviors.

How Spirituality Can Affect Risk

In understanding and assessing the context in which risk behavior occurs, counselors must also assess clients’ values, beliefs, and motivations for continuing or changing their risk behaviors. The counselor’s job is not to interpret a client’s religious beliefs, but it is helpful for the counselor to know if such beliefs are a part of the client’s rationale for continuing or ceasing risk. It is also important to recognize that although some clients may not, themselves, subscribe to a particular religion or set of beliefs, there are perhaps no more powerful “ghosts” or influences than those of a person’s religious heritage and childhood training.

Counselors must be open to asking clients questions about how religion and spirituality affect a client’s views toward risk and HIV infection, while recognizing each client’s individuality in terms of the ways in which religion or spirituality has affected him or her. It is ineffective, for example, to see a client as a being a “typical” Christian, Taoist, or Hindu. At the same time, counselors must not assume that a particular practice, such as not using condoms and a client’s statement that “it’s not right” to use them, is necessarily predicated upon the client’s religious views.

Religious and spiritual teachings often present behaviors and beliefs in absolute terms of being either good or bad. Problems can result when clients apply such absolute concepts to HIV risk behaviors. For example, people may reinterpret or deny their behavior to avoid seeing it as bad. Or, they may define behaviors as bad and generalize this to mean that they are bad people. Either case might lead clients to fail to disclose their behaviors.
or concerns to counselors. In addition, because people may apply religious or spiritual concepts of good and bad to many areas of their lives, they may look to counselors for absolute answers about which sexual or other risk behaviors are good or bad. Counselors can be alert to this possibility by listening for such value-laden terms as “good” or “bad.”

Related to this, some religious teachings do not differentiate behaviors from fantasies. As a result, people may believe that having fantasies about certain behaviors, for instance, unsafe sex, is itself right or wrong. They may not believe that they can talk about such fantasies, or they may not differentiate such fantasies from actual behaviors in terms of their risk for infection.

Honoring the Client’s Beliefs

Although counselors are trained to discuss difficult subjects with clients, religion remains a challenging topic for many counselors. For many clients, however, religious upbringing and currently held beliefs contribute to attitudes and behaviors surrounding HIV risk. These influences may emerge directly or indirectly as the client discloses HIV risk and other information. It is important for the counselor to listen for this information and refrain from misappropriating it to serve his or her own religious agenda rather than the client’s counseling needs. To avoid this, counselors should examine their own issues about religion and spiritually-based beliefs outside the counseling session. Counselors should not assume religious affiliation or spirituality nor project any sense that being of a particular religion or belief system is right or wrong. The counselor who initiates a discussion of sin, for example, and refers to a text from his or her faith tradition is engaging in inappropriate behavior.

It is also inappropriate to challenge religious beliefs or to enter into dialogue that clients may construe as an attempt to interpret or redefine their religious beliefs. For example, if a female client states that she cannot ask her male partner to use a condom because it is against her religion to use condoms, it is inappropriate to tell her she is misinterpreting her faith tradition or that her values are somehow incorrect. It is appropriate, however, to place this information in the larger context of what the client is saying about what she wants for herself. If this client states that her religion prohibits her from using condoms, that she is concerned about becoming infected with HIV, and that she intends to continue having intercourse, her counselor needs to acknowledge this apparent contradiction and the dilemma it must present for the client.

By asking the client, “What ways, other than using a condom, can you avoid HIV risk in the future?” the counselor acknowledges the power of the client’s beliefs and the challenge she faces. The client’s response to this question can help her and the counselor to troubleshoot the situation and to assess whether or not the client perceives having any control over making a change to reduce her HIV risks.

Some counselors may feel they do not possess the tools to appropriately respond to matters of religion or spirituality. Most situations, however, require little more than basic counseling skills. For instance, when a client denies personal control of his or her HIV risk and confers it upon another person, such as a sex partner, counselors should remember to maintain neutrality and address contradictions. For example, when a client says, “I must protect my health so that I can care for my children,” and “I cannot use condoms because it is against my religion,” the counselor might point out how the client’s comments contradict one another, at the same time being careful not to challenge the client in a direct manner.

A client’s attitudes and behaviors may be directly influenced by his or her own religious convictions, and this may raise some crucial counseling issues. For example, a client may find that his or her religious beliefs attack his or her sexual orientation. The denigration of homosexuality in the name of religion might understandably elicit rage, and, when a client does not allow him or herself to feel this anger, it can also fuel depression. To determine if a client is internalizing negative messages

References

like this one, explore which messages are meaningful, how the client interprets them, and the resulting effects on emotional health. When possible, point out contradictions and consequences of personal beliefs, and explain the process by which people internalize religious or spiritual beliefs. In this way, it may be important to explore the “part” of the client that, for example, accepts homophobic messages. The goal in addressing these matters is to help the counselor determine if the client’s self-denigration, which can be rooted in religion, contributes to his or her HIV risk behavior.

Be aware that religious and spiritual beliefs vary greatly among religions. Behavior that some people may view as superstitious and inconsequential could be a deep and abiding part of another person’s faith. A client might, for example, view the concept of luck as being a crucial part of his or her well-being. This client may believe that recent “bad luck” must mean he or she is going to become infected with HIV in the future. The counselor need not directly address the concept of luck. Instead, the counselor can look at how the client can increase the possibility of having “good luck” in avoiding HIV in the future. Among the ways the counselor might do this is by suggesting the client use a protective barrier during sex. It is important for counselors to explore what a client means by “good luck” or “bad luck” in order to determine where the client perceives the control, for example, in changing behavior to be.

Religious or Spiritual Resources

Depending on a person’s coping mechanisms, internalized negative messages about homophobia, sexism, racism, or other forms of oppression and discrimination can be devastating to a client and to others if left unattended. Although exploration of deeply rooted beliefs and societal messages often requires more time than is available during an HIV test counseling session, naming the issue and validating positive self-regard can facilitate linking the client to outside resources for further counseling. Counselors must be careful when making referrals to clergy or religiously affiliated lay resources. Counselors should explore with the client what kind of referral he or she might find most helpful. In either case, a referral to the individual’s religious leader or to a non-religiously connected counseling resource may be appropriate. If religious matters are dominant for the client, ask if he or she has ever consulted or considered consulting clergy about these matters. Listen for the direct and indirect messages about how safe and comfortable consulting his or her particular clergy person about HIV related concerns—the experience has been in the past and how it might be.

If a client requests a referral to clergy, as with therapists, it is important to provide at least three different resources whenever possible, so it is the client making the choice, not the counselor. In some communities, religious leaders have been in the forefront of AIDS education and support efforts. Whenever possible, it is helpful to refer clients to religious or spiritual advisors who are knowledgeable about and sensitive to HIV concerns.

The Challenge of Remaining Neutral

It is well beyond the scope and boundaries of counseling for counselors to discuss their own religious beliefs with clients, even if a counselor believes that he or she can resolve a client’s dilemma. Further, it is inappropriate for a counselor to refer to a religious text for consultation or prayer during a test counseling session.

A counselor may feel conflicted about specific religious teachings, for example, regarding adultery. Counselors must always maintain a non-judgmental stance with clients and whether a counselor believes sex outside of a marital bond to be immoral or neutral, it is the client’s beliefs that should determine how the session unfolds. If a client senses the counselor has judgments about his or her behavior the client may “shut down” to further discussion—leaving risk reduction unexplored—or experience increased feelings of shame and guilt. Such feelings might then lead to self-punishing behaviors that involve increased HIV risks.

Religiously based beliefs and attitudes affect counselors as well as clients. While a counselor may not currently subscribe to a particular religion or set of spiritual beliefs, religious history may raise in the counselor feelings and responses when a client shares material that has religious content or over-tone. For example, a counselor who was raised as a Catholic and was told adultery was a “mortal sin” may reject this belief system. When confronted with a client who identifies as a practicing Catholic and reports engaging in such behavior, however, the counselor might identify with the troubling nature of this client’s dilemma and inadvertently add to the client’s shame if the counselor communicates verbally or non-verbally any agreement with the judgment. Alternately, the counselor may have
rejected Catholicism with such force that he or she is unable to empathize with the client’s struggle and this may lead the client to feel isolated. Counselors must also be cautious not to over-identify, especially with clients who hold similar views or who come from the “same” religious tradition as the counselor. Clients are best served when counselors detach from personal struggles or experiences.

In order to provide a truly neutral environment in which clients may explore HIV risk issues, counselors should be mindful of their own issues surrounding religious beliefs. Attending a diversity training may help counselors explore their own values and make room for divergent values. Counselors should explore with their supervisors any religious or other personal issues that may interfere with their ability to counsel effectively. If such issues arise for the counselor during a session, good self-observation and detachment skills can help the counselor focus and attend to the client appropriately. In an HIV counseling session, the only personal views that matter about religion, spirituality, interpretation of religious tenets, or related matters, are those of the client.

**Conclusion**

Sexuality and spirituality are two of the most intimate subjects for many people. When HIV risk behavior is directly or indirectly influenced by religious or spiritual beliefs or practices, counselors must address this, using fundamental counseling skills, such as remaining neutral, addressing contradictions, providing validation and using other tools to facilitate this process. When counselors show respect for the personal nature of sexuality and spirituality, clients may be better able to consider and discuss ways in which spirituality affects their thoughts and actions related to sexual expression and HIV risk taking.

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**Case Example:**

**Risk Reduction and Religion**

Louise is a 28-year-old woman who has received a seronegative HIV test result. In the risk assessment session, Louise had reported that her husband has had other sex partners and injects drugs. During the disclosure session, Louise’s counselor, Brian, reiterates that Louise is at substantial risk for HIV infection. Louise states that because she is a devout Catholic, she does not believe in using condoms.

After clarifying with Louise the risk behaviors in which she engages, Brian asks her the reasons she sought testing. To explore Louise’s own motivation to decrease risk, Brian asks her what would happen if she contracted HIV. When she responds with uncertainty, he asks her to look ahead five years and imagine what might be going on at that point for her and for those she loves if she were HIV-infected. She states that HIV would be an unbearable hardship on herself and her family.

In further discussion, Louise refers both to her husband and to God as having control over her and the decisions she makes. Brian senses that Louise believes she has little control to make changes in her life. He explores both the sense of control that Louise attributes to her husband and to God, distinguishing one from the other. Brian believes that by recognizing that she has some control, Louise can increase her ability to make decisions and decrease risk.

Brian asks Louise if she is a member of a particular church community and if a religious leader or others in this community are aware of the HIV risks in her life. Louise says that her priest is not aware of her risks and that she would feel uncomfortable talking to him about this issue. Brian asks if there is anyone else—a nun or a lay leader—with whom Louise would feel comfortable discussing this. When Louise says no, Brian considers offering Louise referrals to clergy from other Catholic church communities or from different faith traditions so that she can discuss her religious concerns in light of her HIV risks.

Louise says she wants to arrange an intervention with her husband. Brian discusses with her the possibility of involving her husband in counseling and testing or for marital counseling at another resource. He listens for the presence or lack of hope in her response. Louise acknowledges she is thinking about making a change but does not yet have a vision of how that can happen. In response, Brian links her to a resource that can help her consolidate her religious conviction and her desire to engage in safer behaviors, and he emphasizes Louise’s motivation to stay safe as the reason for her to follow-up on a referral.
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