Healing HIV: Mind, Body, and Spirit
Elisabeth Targ, MD

Recently, with the 1998 inauguration of the National Center for Complementary and Alternative Medicine by the National Institutes of Health, there has been an explosion of interest in “mind/body medicine.” Most of these therapies are designed to enlist the individual’s body, mind, or spirit in service of the healing process. This often means using mental or emotional strategies to influence physical processes, but it can also mean using a physical process such as movement to influence mental, emotional, or spiritual states. These therapies epitomize the notion of “holistic” healing.

Within the context of mind/body medicine, healing may focus on the physical: combating illness, relieving the side effects of medications, or decreasing pain or nausea. At the same time, the mind/body practitioner actively helps the individual develop a more interactive and personal relationship with his or her illness. When this approach is successful, patients develop a better sense of the meaning, and perhaps even the gifts, of their illness in the context of their unfolding life. Mind/body therapies may include conventional interventions such as psychotherapy or biofeedback, or unconventional interventions such as meditation, imagery therapy, yoga, expressive arts therapies, or spiritually based therapies. The NIH Center defines its purview beyond such mainstays as herbal products and acupuncture, and over the past two years has funded studies into “intercessory prayer,” “bio-energetic medicine,” and spirituality.

The Complementary Medicine Research Institute at the California Pacific Medical Center in San Francisco has undertaken two studies of prayer and “distant healing” among people with HIV. This article reviews the literature on mind/body medicine and its application to HIV-related conditions, focusing on the role of spirituality and, regarding these studies, the evidence for the value of distant healing in the context of HIV disease.

Mind/Body Medicine

Although the concept of spirituality is often seen as peripheral to conventional Western medicine, many alternative medical systems such as traditional Chinese medicine, the East Indian “ayurvedic” healing, and Tibetan medicine are intimately linked to spiritual belief systems. The use of prayer, contemplation, visualization of “energetic flow,” and sacred images, teachers, or deities figures heavily in Asian, Native American, and shamanic healing systems. Imagery therapies, metaphor, ritual, and some expressive arts therapies, widely used by modern transpersonal psychologists, have long been the tools of shamanic healers worldwide.

Some of these interventions are aimed not just at relieving symptoms and curing disease, but also at promoting growth into a fuller and more vibrant state of being and a sense of integration at the time of death. Although often euphemistically labeled in the United States as “stress management” to make them more broadly marketable to our secular society, yoga and meditation evolved in the context of programs for spiritual development. The word “yoga” means “union.” Hatha yoga poses were originally designed to increase awareness and facilitate “energy flows.” Likewise, breathing techniques were meant to “balance and still the mind” to facilitate meditation and the transcendence of the self.

There has been a tremendous increase in the desire to incorporate spiritual assessment and exploration into medical treatment for people with catastrophic illness. In one study of elderly medical patients, 50 percent of respondents said spirituality was an important factor in their healing.¹
There are two types of people in the world: those for whom faith is a comfortable, even preferable, attitude; and those for whom tangible proof is a requirement.

In the realm of HIV, which is scientific by nature, data-based evidence is central to what we know and to how we make decisions about everything from medical treatment and prevention strategy to psychotherapeutic approach. This orientation makes it difficult to acknowledge the role of faith, religious or otherwise, in the actions of the people targeted by these interventions. In fact, many equate “faith” with “fatalism” and passive coping, both of which have been associated with poorer psychological and medical outcomes.

In this issue of FOCUS, Elisabeth Targ and Anne Richards discuss the role of prayer—Targ talks about it in more specific terms as “distant healing”—in both the physical and mental health of people with HIV. Targ, who in a presentation at the AIDS Health Project admitted to having herself been a skeptic of the power of distant healing, presents the topic in a particularly compelling manner for those of us who may be of “tangible proof” orientation.

She puts “distant healing” into the context of mind/body medicine and describes the accumulation of scientific data that suggests the power—unexplainable at the moment—of distant healers whose “intercessory prayers” have material effects on the physical health of patients miles away. Richards looks at the literature on prayer to offer a description of the types of prayer, the ways they manifest, and the psychological benefits for people who pray.

While people working with HIV may be more aware than most of how the teachings of some organized religions have undermined both societal prevention and care efforts and individual emotional and physical health, Targ and Richards have expansive views of how prayer fits into life, perspectives that include and go beyond religion per se. These perspectives offer medical and mental health providers who seek to be client-centered a way to understand the role of prayer in their clients’ lives, and the beginnings of a scientific explanation for the power of the mind seeking communion.

When I said there were two types of people, I lied, and you’ve probably seen through this lie already. I find myself somewhere between the worlds of faith and skepticism. It may be that this in-betweenness is exactly the place for providers to be when dealing with clients, that it is, in fact, the very essence of the empathy that is so central to working with people.

In another study, 75 percent of medical patients wanted their physicians to ask them about their spirituality, although only 10 percent said that their physicians had done so. In a survey of urban hospitalized patients, 40 percent wanted their doctors not only to pray for them, but with them. As a result, more than 60 medical schools and nearly 30 psychiatry residency training programs include courses in spirituality. These courses teach new doctors to ask their patients about their spirituality and to explore whether or not patient beliefs or spiritual community may be resources in the healing process.

**Spirituality and Healing**

Spirituality refers to the beliefs and behaviors that relate to an individual’s experience of a transcendent or intrinsic source of meaning, purpose, and connectedness. Independent of religious background, individuals who describe spirituality as important in their lives have been shown to achieve reduced levels of anxiety and depression, better health, greater longevity, and greater tolerance of surgery. While people working with HIV may be more aware than most of how the teachings of some organized religions have undermined both societal prevention and care efforts and individual emotional and physical health, Targ and Richards have expansive views of how prayer fits into life, perspectives that include and go beyond religion per se. These perspectives offer medical and mental health providers who seek to be client-centered a way to understand the role of prayer in their clients’ lives, and the beginnings of a scientific explanation for the power of the mind seeking communion.

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spatial perspectives. For example, a recent national survey found the use of complementary therapies was significantly higher among individuals endorsing the statement “The health of my body, mind and spirit are related, and whoever cares for my health should take that into account.” In addition, use of complementary therapies was highly correlated with the statement, “I’ve had a transformational experience that causes me to see the world differently than before.” Many individuals report that their encounter with catastrophic illness stimulated a “spiritual search” which they believed contributed to improved quality of life or medical outcomes.

At the same time, such popular views may lead other patients to feel guilty for having “failed” at a spiritual search. This phenomenon has been termed “new-age guilt.” For example, one study found that 39 percent of breast cancer patients believed that it was “their personality,” or behavioral factors that caused their cancer. In addition, some suggestion that HIV, cancer, and other diseases are the result of psychospiritual “blocks” that arise from negative feelings, thoughts, or behaviors. While these ideas may help create a framework for working with illness, there is no scientific evidence to support such a concrete cause-and-effect relationship. For this reason, it is important to clarify through research which attitudes and beliefs are associated with improved coping, and which may promote further demoralization. For instance, at the Complementary Medicine Research Institute, studies of women with breast cancer found that believing “my illness is meant to teach me something” was associated with better quality of life and less depression, while believing “my illness is a punishment” was associated with worse quality of life.

**Distant Healing and the Role of Prayer**

Many people think of “spirituality” as relating to institutional beliefs or communities of shared culture. They assume that any health benefits of spiritual practice arise out of social support, hope, or expectation of healing. However, at its foundation, spirituality describes something that connects people beyond the physical or the emotional. The formal scientific study of prayer and “distant healing” is an attempt to address this aspect of spiritual practice, separate from a kind of social support or the “placebo effect” that might be attributed to the expectation of healing.

Distant healing refers to treatments that involve one person’s actions to heal another through various forms of “intentionality effects on living systems.” Such treatment modalities include some forms of prayer, ritual, spiritual healing, “bioenergy healing,” or meditative techniques. Studies have found that both people with HIV and those with cancer frequently report adopting various types of prayer and spiritual practices as an adjunct to medical treatment. Although these interventions have been the object of relatively few published studies, they are widely available in the community and are the subject of intense public interest.

Active “intentionality” is incorporated into numerous alternative therapies such as body work, imagery, chi gong and movement therapy, even when they are not explicitly designated as prayer or distant healing treatments. These therapies are often based on one of two notions: either a practitioner “holds a compassionate intention” for the well-being of the patient, or the practitioner imagines “sending” healing, light, or love to areas of physical need or discomfort. It is important to formally study these ideas, because they are widespread and because they may play a significant role in the provider-patient relationship.

As of 1992, there were 131 published formal laboratory studies on distant healing, primarily on animals and cell preparations. Of these, 56 found statistically significant results. Studies in this area require extremely careful blinding and monitoring of potential confounds such as hope, expectation, and the provider’s relationship to the patient. Several clinical studies have come to national attention. A 1988 report described improved outcomes in a large double-blind study of intercessory prayer in a coronary intensive care unit. A positive replication of this study, with another 900 patients was recently published in the *Archives of Internal Medicine*. Another double-blind clinical study found that the use of intercessory prayer in hernia surgery patients resulted in significant benefit on nine of 24 outcome measures, including success of wound healing, general health outcome, and incidence of infection. Together, these

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**References**


studies strongly support the possibility that healing intention over distance may have a direct effect that is independent of a patient’s beliefs or expectations.

**HIV and Prayer**

The Complementary Medicine Research Institute recently published results of two double-blind studies of prayer and distant healing for people with advanced HIV disease. The initial idea for these studies came about in the mid-1990s, when there were few successful HIV treatments available. Psychologist Fred Sicher suggested that if distant healing were helpful for this condition, it might be something that friends and family could offer a person with HIV.

In the larger of the two studies, 40 people with CD4+ cell counts of less than 200 were randomized to receive either their usual care only (control condition) or to receive “distant healing intentions” one hour a day, six days a week for 10 weeks. Distant healing was undertaken by highly experienced healers located all over the United States. All the patients were in San Francisco. Healers were given the first name and a photograph of the patient, but patients did not know whether or not they were in the healing group. Healers were instructed to “hold an intention for the health and well-being of the patient for at least one hour per day.” Healers were allowed to use whatever means their training or tradition dictated to accomplish this. Interventions included prayer, imagery, rituals, meditation, and even hands-on healing of a “mock-up” of the patient.

At the end of six months, medical chart reviews found that patients in the healing group had six times fewer AIDS-defining illnesses and less than half the average “AIDS severity scores” of those in the control group. The treatment group also had significantly fewer outpatient doctors visits (185 versus 260) and significantly fewer days of hospitalization (10 versus 68). In addition, patients in the healing group showed significantly lower psychological distress, depression, anger, and confusion.

The striking nature of these results has led the National Institutes of Health to fund an ongoing replication of this trial. In the new study, prayer by experienced healers will also be compared to prayers and distant healing efforts by nurses. The first studies confirmed that distant healing could be effective when performed by highly experienced healers, but they did not confirm whether it could be incorporated, as Sicher proposed, into community support or mainstream medical situations. The Complementary Medicine Research Institute is also looking at the personality, belief, and spiritual factors that are associated with distant healing ability.

**Conclusion**

An abundance of research demonstrates that illness is much more that a bodily dysfunction; it is part of the story of an individual’s life and personhood. Any treatment that does not include attention to who the patient is in his or her family, community, or life narrative will be incomplete. While most studies of mind/body therapies use standard outcome measures—did the person live longer? have lower blood pressure? have less anxiety?—it is always important to remember that spiritually based interventions were invented with a different purpose. These interventions open the door not only for repair of disease but also for growth related to our sense of who we are and why we are alive. They introduce qualities of awe and transformation into a practice that has been mechanical and dry, and continuing broad-based research will help determine how mind-body interventions can be further integrated into everyday health care.

### References


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Let the beauty we love be what we do. There are hundreds of ways to kneel and kiss the ground. — Rumi

Prayer does not rise up out of the intellect but rather is an act of the heart, an act of communication that seeks to find the connection between a person's being and the ultimate. "Ultimacy" refers to how an individual construes or imagines his or her existential condition or environment.¹ How a person conceives this ultimacy is less important than his or her act of seeking out the connection, and it is this connection to the ultimate that distinguishes prayer as a transcendent act. Writing about prayer can never truly capture the essence of the act; however, this article attempts to convey a glimpse of how prayer occurs in the lives of people living with or in proximity to HIV disease.

Circumstances of Prayer

There are conditions of life that draw prayer out of us. Three are particularly relevant to HIV: suffering, the need for guidance, and a sense of awe or wonder.

Suffering cannot be denied as part of the human condition. Whether HIV is viewed as a chronic illness or a terminal one, it engages physical, psychological, emotional, and existential suffering.

Prayer also arises out of the need for guidance, direction, or clarity in life decisions. There is a Zen Buddhist saying: "Life is without difficulty, save for the picking and choosing." The intensity of decisions regarding health, relationships, finances, and other matters increases in the context of the threat of illness or death. In the midst of this intensity, confusion can cloud the decision-making process, limiting insights into available options.

Finally, prayer is a response to a sense of awe, existential wonder, or the sense of being blessed in life. These experiences are most typically prompted by exposure to beauty and love. Spending time in nature, experiencing the love of a child or a partner, enjoying art or music; these are among the vehicles for spiritual sensation. Under these circumstances, prayer is a response to a spontaneous connection to the ultimate, and most typically, is an expression of gratitude.

Types of Prayer

Typologies of prayer exist as frameworks to study how people pray.²-⁴ The following classes of prayer—colloquial, ritual, meditative, and living—exist in the lives of economically impoverished women living with HIV disease. Journal of Pastoral Care. 1998; 52(3): 227–240.


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See also references cited in articles in this issue.
scholarly literature, and are substantiated by qualitative data from people living with HIV and their caregivers.

Colloquial prayer is conversational, sometimes petitionary, and frequently enacted silently. It has been described in qualitative studies as an internal communing with the sacred during regular daily activities such as riding the bus, walking down the street, or gazing out a window. A colloquial prayer can be a long conversation or as simple as “May I find peace with myself,” “Give me strength,” or “Thank you.” Personal prayers of this nature are encouraged in some monastic traditions, as they are simple expressions of the heart.3

Ritual prayer is more formal and structured. Participation in religious or spiritual ceremony, the recitation of written prayers, or readings of sacred or inspirational texts are forms of ritual prayers. Thus, this type of prayer draws on the words and interpretations of others in order to grasp an expression of spiritual life beyond one’s own. Ritual prayer may happen in private or with a congregation.

Meditative or contemplative prayer is grounded in inner silence. The movement into the silence is typically guided by attending to breathing, repeating a prayerful phrase, or fixing the gaze upon an object such as the flame of a candle or the ocean’s horizon. Like ritual prayer, meditative or contemplative prayer may happen in private or with a congregation.

Living prayer is often an outcome of intense engagement in prayer or profound spiritual experience. All activities of living become prayer, life is perceived as sacred, and the individual is imbued with a spiritual sense. It may appear that only people such as Mahatma Gandhi or Mother Teresa achieve this state of prayer. In fact, the imbued person is more common than we imagine.

Benefits of Prayer

When we become aware of our place in the larger scheme of things, daily life becomes more spontaneous and meaningful, and our actions serve life naturally.6

Engagement in prayer provides many individuals with an opening of awareness, expanding their capacity for realization and development. When this capacity is expanded, there is greater and more frequent access to clarity, purpose, meaningfulness, and gratitude, and an experience of unity with the world. Prayer then becomes a tool that diminishes alienation and feelings of isolation and increases joy, love, peacefulness, and appreciation.

Prayer also provides individuals with guidance for skillful living. As awareness expands, so do choices around personal conduct, work life, health, and treatment of illness. While we may not be able to alter certain life circumstances, we can become more skillful in how we respond to them. Cultivating the ability to respond skillfully increases an individual’s sense of worth and self-efficacy.

Coping through prayer frequently occurs when an individual perceives that the conditions of a situation are beyond personal control. The efficacy of prayer as a coping mechanism is partly dependent on the individual’s faith and whether the type of prayer he or she selects is in accordance with this spiritual worldview, that is, his or her construct of the ultimate. Prayer as an effective coping mechanism functions to recontextualize experiences so that depression, anxiety, hopelessness, anger, or fear is balanced with trust, compassion, positive morale, or the development of positive meaning.

Conclusion

Many HIV-infected individuals and their caregivers actively practice some form of prayer. Prayer emerges from within and so to prescribe prayer as a means of coping will not necessarily be an effective mental health strategy. Acts of prayer that are beneficial to well-being occur within the construct of an individual’s spiritual worldview. Unless a therapist has a psychospiritual practice, the therapeutic setting may not be a fitting environment for introducing a person to a prayer practice. However, it is always beneficial to discover whether prayer is a resource used by the client. Further, it is useful to gain an understanding of the client’s spiritual worldview as well as sources of love, beauty, and meaning within the individual’s life.

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 remarks@itsa.ucsf.edu or to Editor, FOCUS, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.
Prayer and Medication Decision Making
Crane JR, Perlman S, Meredith KL, et al. Women with HIV: Conflicts and synergy of prayer within the realm of medical care. AIDS Education and Prevention. 2000; 12(6): 532–543. (Barnes-Jewish Hospital, St. Louis; and Washington University, St. Louis.)

Ninety-two percent of a sample, made up predominantly of African American women with HIV, reported that prayer was important in HIV medication decision making, and 66 percent said that prayer was more important than the medical advice of physicians in this decision-making process.

Interviewers conducted the surveys of 130 women living within a 12-county region of Missouri and Illinois from November 1998 to February 1999. Eighty-eight percent of the women were from metropolitan St. Louis. Eighty percent of study participants were African American, 18 percent were Caucasian, and 2 percent were Hispanic, Asian, and other races. Participants ranged in age from 13 years to more than 40 years.

Participants combined extrinsic sources (for example, physicians, family members, and informational material) and intrinsic (for example, prayer, beliefs, and attitudes) sources in their medical decision making. In general, participants used prayer as a form of guidance and intercession. Thirty-five percent said that the main objective of prayer was to make decisions about HIV medication and for help taking the medication as prescribed, while 60 percent said that while HIV-related issues were not the reason for prayer, these issues were included in their prayers.

Sixty percent of the women noted a difference between the direction received from praying and the direction received from their physician about the HIV medication. They suggested that doctors direct their body and its reactions, but they associated prayer with God, the soul, and true identity, suggesting that prayer guides the soul, the place where inner peace and strength is located. Still others found that God provides their ultimate guidance because when their doctor’s wisdom fails, a wisdom far more powerful still exists.

The Influence of Spirituality on Well-Being

In a survey of people living with HIV, 42 percent of respondents agreed and 35 percent disagreed with the statement that formal religion provided them with a sense of hope. Overall, there was a relationship between higher levels of spirituality and social support, active problem solving, and life satisfaction. In addition, 58 percent of participants disagreed with the notion that AIDS is a form of divine punishment.

Researchers surveyed 275 participants at nine AIDS service organizations in Wisconsin; 81 percent were men and 19 percent were women. Respondents had a mean age of 37 years and had completed an average of 13.5 years of education. Seventy-two percent of participants were White, 19 percent were African American, 3 percent were Hispanic/Latino, and 6 percent were of other ethnicities.

The survey included five subscales: Prayer Practices, Alternative Practices (primarily health-related), Formal Religions, Spiritual Beliefs, and Punishment (this last subscale asks whether respondents think that their disease is God’s punishment towards them). The effect of each practice was assessed in terms of sexual behavior, physical and emotional well-being, loneliness, social relations, and coping.

Forty-six percent of participants reported praying every day, and only 7 percent said they never prayed. Moreover, 40 percent agreed with the statement that...
formal religion helps people move from a life of fear to a life of love; only 25 percent disagreed with this statement. In addition, 65 percent agreed that there is life after death, 76 percent agreed that a higher power cares for them, and 66 percent said that they believe in miracles. Those who were most likely to participate in religious and spiritual activities tended to be female and non-White.

Compared with respondents who engaged less often in prayer, those who engaged in prayer more often used adaptive coping methods—for example, active problem solving—more frequently and were more likely to have fewer male sexual partners, to be an ethnic minority person, and to receive support from family members. Higher rates of “alternative practices” were associated with increased use of adaptive coping and decreased levels of any HIV-related symptoms. Placing a higher value on formal religion was correlated with more frequent use of adaptive coping strategies, being non-White, using less “planful” problem solving strategies, and receiving more support from family members. Higher levels of spirituality were associated with using adaptive coping strategies, being non-White, being female, receiving more support from families, and having a good relationship with physicians. Finally, believing that AIDS was not a punishment from God was associated with being more educated, being White, being male, and receiving more support from friends.

Religion, Depression, and Immune Status

A survey of HIV-positive gay or bisexual men found that “religious coping”—for example, putting trust in God, seeking God’s help, and praying more than usual—but not “religious behavior”—for example, service attendance and prayer—was related to fewer depressive symptoms. On the other hand, religious behavior but not religious coping was significantly associated with increased CD4+ cell count. Of the sample of 106 men, 55 percent were White, 30 percent were Hispanic, and six percent were African-American. The mean age of the participants was 35 years. Forty-eight percent reported being raised Catholic, 28 percent reported being raised Protestant, and eight percent reported being raised Jewish. Assessment included CD4+ cell count, and measures of depression, coping, self-efficacy, and use of religious resources.

The associations between religious coping and depression and religious behavior and immune status were not mediated by self-efficacy or the ability to actively cope and were independent of symptom status. Self-efficacy did appear to contribute uniquely to lower depression scores.

The finding regarding the relationship between religious coping and depression is consistent with earlier studies. Religious coping, may be associated with an openness to working through feelings and the surrender of control to a “higher power.” This kind of “emotional soothing” (active emotion-focused coping) may also be related to lower distress levels and better immunological and health status.

In addition, the fellowship with others encouraged by religions may facilitate expansion of the social support network and the perceived quality of personal relationships within networks. Social support works to buffer the effects of stress and to help a person deal with and recover from serious illness. Religiosity is also associated with a diminished fear of death among cancer patients and geriatric populations. Fear of death has been associated with poorer health outcomes within certain HIV populations. Finally, religious involvement is associated with health-enhancing behaviors such as diet, stress management, and medication regimens.

Next Month
Two key interventions for reducing HIV risk among injection drug users—needle exchange and methadone maintenance—fall into the category of harm reduction, strategies that do not eliminate drug use but make it safer for both drug users and for society. In the February issue of FOCUS, Bahman Nedjat-Shokouhi, a medical student at the Royal Free and University College Medical School in London, reviews the recent needle exchange literature and reports on the success of this strategy and the extent to which the literature supports concerns about such programs.

Also in the February issue, Martin Iguchi, PhD, Director of the Drug Policy Research Center at RAND in Santa Monica, California, describes methadone maintenance and the way it reduces HIV-related risk.
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