

Original Article

Role of Spirituality as a Coping Method for Psychological Distress in People Living with HIV/AIDS

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ABSTRACT

Objectives: Human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome disease is one of the most devastating illnesses, which has a significant negative impact on the biopsychosocial and spiritual well-being, with a high prevalence of psychological distress (PD). Spiritual coping is observed to reduce PD. This study aimed to identify the presence of PD among patients living with HIV (PLHIV), assess their spirituality and spiritual coping, and the association with PD.

Materials and Methods: This descriptive study employed a cross-sectional design. A sample of 50 PLHIV was selected from the Infectious Disease Clinic and the antiretroviral therapy (ART) Centre of a tertiary hospital. Selected demographic and clinical data were collected. The general health questionnaire (GHQ), World Health Organization quality of life (QOL)-100 Domain VI, with QOL 100 additional spiritual, religious and personal beliefs questionnaire, and Spiritual Coping Methods Assessment Questionnaire were administered to measure PD, spirituality and utilisation of spiritual coping methods, respectively. The data were analysed using frequency, percentage and Chi-square.

Results: The findings indicated that 28% of PLHIV had PD, and 92% had a high spirituality score. The spirituality was inversely related to PD ($X^2 = 13.8$, $p < 0.001$). The majority (86%) of patients had high utilisation of personal and corporate spiritual coping methods. Those patients who utilised more personal and corporate coping methods were found to have less PD. Gender, marital status, occupation, time of diagnosis, stage of disease and ART status showed no significant association with PD.

Conclusion: PD prevalent in PLHIV is significant, and patients who had a high spirituality score and used more spiritual coping methods were found to have less PD. Therefore, PD among PLHIV must be evaluated and spiritual needs addressed as a part of HIV care. Patient-centred spiritual coping strategies can be considered during counselling of PLHIV.

Keywords: Coping, Patients living with human immunodeficiency viruses, Psychological distress, Spiritual coping, Spirituality

INTRODUCTION

Human immunodeficiency viruses/acquired immunodeficiency syndrome (HIV/AIDS) is a chronic, incurable disease that progresses into a life-threatening condition. Globally in 2024, 40.8 million people were living with HIV. Since 2010, new HIV infections have declined from 2.2 million to 1.3 million in 2024.^[1] India's burden of HIV is very high. An estimated 2.6 million people were living with HIV in 2024.^[2] With access to effective HIV prevention, diagnosis, treatment and care, it has become a manageable chronic health condition, enabling people to lead long and healthy lives.^[3] The comorbidity of HIV/AIDS and mental health problems presents a major health challenge.^[4] Few studies

have reported a higher prevalence of anxiety and depression or psychological distress (PD) with increased vulnerability among females.^[5-8] High prevalence between 30.5% and 51% was reported in several studies conducted in India, Spain and Nigeria.^[9-13]

The people living with HIV/AIDS undergo various traumatic experiences such as stigma, physical suffering, lack of support, isolation and loss of loved ones. To cope with these challenges, individuals often resort to various coping mechanisms. Spirituality is an important resource that individuals use to cope with a chronic illness such as HIV.^[14] Spirituality refers to an individual's connection with the divine and is a more personal experience, whereas religiosity is a more structured

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form of following religious practices. Religious involvement and faith may often be invoked in life-threatening health conditions such as HIV.^[15,16] Religiosity and spirituality have been shown as significant coping strategies among patients living with HIV (PLHIV).^[17-19] In a study done on HIV adults in Tanzania, spirituality was positively related to active coping and social support and was found to mediate the relationship between religiosity and spirituality and PD.^[20] Overall positive spiritual coping significantly predicted greater survival over 17 years, indicating that people using spiritual strategies were 2–4 times more likely to survive.^[21] The World Health Organization (WHO) has recognised spirituality as a dimension of quality of life and recommends including psychosocial support as an important part of the continuum of HIV care. The World Psychiatric Association advises national psychiatric associations to include the spiritual dimension in mental health evaluation and treatment. The General Medical Council, UK, in its guidelines on Good Medical Practice, states that ‘In providing clinical care you must adequately assess a patient’s condition(s), taking account of their history, including relevant psychological, spiritual, social, economic and cultural factors.’^[22-25] All these emphasise the value of spirituality as an important component of the quality of life and mental health. Integration of mental health and psychosocial support with person-centred HIV

services is one of the key priority actions in the Global AIDS Strategy 2021–2026.^[26] There is a significant dearth of knowledge regarding the mental health status among the PLHIV in developing countries like India. There are some studies published about spirituality as a protective coping strategy for PD in PLHIV, but studies on the role of healthcare professionals to address PD and mental health among PLHIV are very scarce. To address this knowledge gap, this study was conducted in a tertiary hospital to identify the presence of PD among PLHIV, assess their spirituality (spiritual/religious and personal beliefs), and spiritual coping methods, and their association with the PD.

Hypotheses: 1. There is a significant reduction in PD of PLHIV with higher spirituality 2. Higher utilisation of spiritual coping methods reduces PD in PLHIV and 3. Selected demographic and clinical characteristics are associated with PD.

MATERIALS AND METHODS

The overall study methodology flowchart is presented in Figure 1.

A descriptive cross-sectional design was used in this study. Adult HIV positive patients who attended the Infectious Disease Clinic and ART Center of Christian Medical College, Vellore, for treatment and follow-up, and who were 18 years

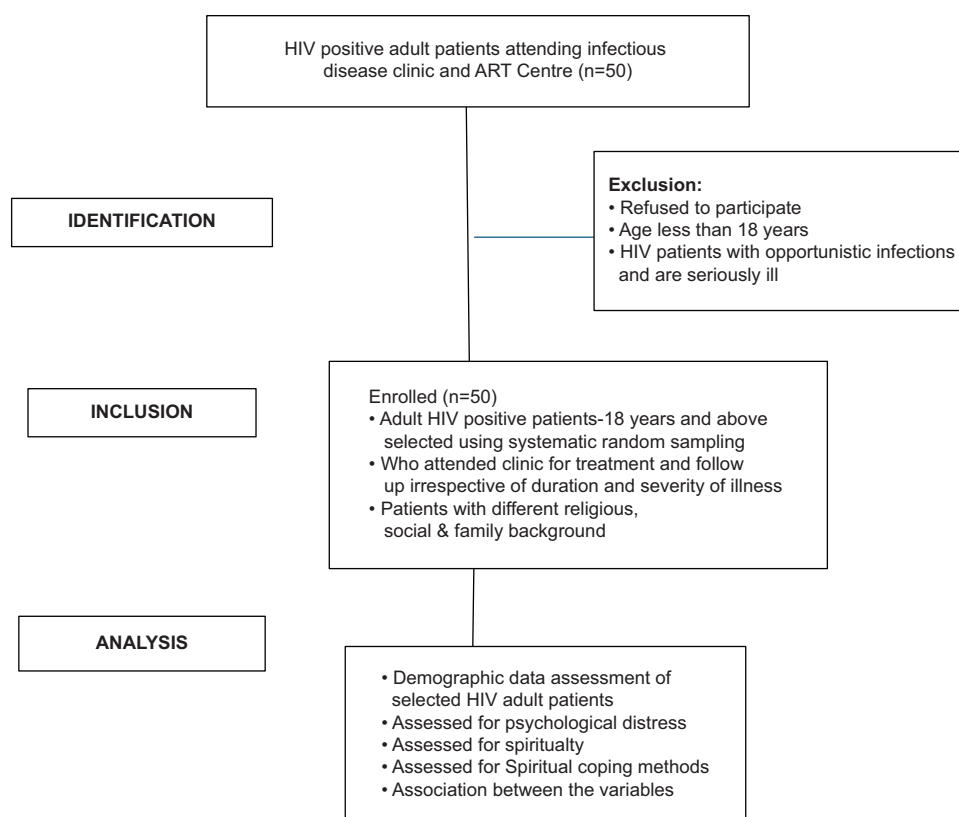


Figure 1: Study methodology flow chart. HIV: Human immunodeficiency virus, ART: Antiretroviral therapy.

and above, irrespective of the duration and severity of illness, were included in the study. PLHIV from different religious, social and family backgrounds in the city of Vellore were included. HIV patients with opportunistic infections and who are seriously ill were excluded. A sample of 50 patients was selected using systematic random sampling. The first patient was selected randomly; following which, every third patient who registered in the clinics was selected for the study. The variables studied were PD, spirituality and spiritual coping.

An interview technique was used to collect the data. Written informed consent was obtained from all the participants. Each participant was assured of the confidentiality of his/her responses and provided a patient information sheet. A structured face-to-face interview was conducted in a calm and comfortable environment in the clinics using quantitative questionnaires by the investigator. Selected demographic and clinical characteristics of the participants, which included sex, education, occupation, marital status, time of diagnosis, stage of the disease and ART status, were collected using the demographic and clinical characteristics assessment questionnaire. The PD in PLHIV was measured using the 12-item general health questionnaire (GHQ) (revised GHQ scoring questionnaire), which is a standardised scale with high validity and reliability. This scale is intended to screen for general (non-psychotic) psychiatric morbidity that is widely used to assess PD in various clinical settings. In this 4-point Likert scale, the responses were quantified. All 12 items are coded 0-0-1-1. The addition of scores for all 12 questions was 12; 4-7 scores were classified as having mild PD, and 8-12 as having severe PD.

The WHO QOL domain VI, with QOL 100 additional spiritual, religious and personal beliefs (SRPB) questionnaire was used to assess spirituality, which is a standardised scale with high validity and reliability. The SRPB, with eight facets consisting of 36 questions, covers quality of life aspects related to spirituality, religiousness and personal beliefs (SPRB). The eight facets include spiritual connection, meaning and purpose of life, experiences of awe and wonder, wholeness and integration, spiritual strength, inner peace, hope and optimism and faith. The questionnaire is a 5-point Likert scale. Each question has 5 answers, and each question is marked as 1-2-3-4-5. Scores 3, 4 and 5 were categorised as high spirituality, and 1 and 2 were categorised as low spirituality. The GHQ and WHOQOL 100 Domain VI are widely used and, as a result, translated into many languages and extensively validated in general and clinical populations worldwide. In this study, these questionnaires were in English, translated into Tamil and independently back-translated to identify and clarify ambiguity of meaning. Respondents were given a choice of completing the interview in Tamil or English. The Spiritual Coping Methods Assessment Questionnaire, a 5-point scale with six questions, prepared by the investigator, was used to assess

spiritual coping methods, which were categorised into two categories: Personal and corporate coping methods. A score of 3, 4 or 5 was considered as high utilisation and score 1 or 2 was considered low utilisation. The personal spiritual coping methods include personal prayer, reading of scriptures and meditation. The corporate spiritual coping methods include attending a common place of worship, attending spiritual retreats, one-to-one counselling and prayer.

Analysis

Descriptive statistics were computed to summarise the sample demographic and clinical characteristics, such as sex, education, occupation, marital status, time of diagnosis, stage of the disease and ART status. The association of these characteristics with PD was analysed using the Chi-square test. Frequency and percentage were used to analyse the overall PD as well as the levels of PD, such as no distress, mild distress and severe distress. Spirituality score and utilisation of spiritual coping methods were analysed using frequency and percentage. High- and low-spirituality score was calculated based on cut off score set in the spirituality tool. High and low utilisation of spiritual coping methods score was calculated according to the cut-off proposed in the respective tool. A chi-square test was done to assess the association of spirituality and utilisation of spiritual coping methods with PD.

RESULTS

Fifty PLHIV participated in the study. Table 1 presents the demographic and clinical characteristics of the patients. Majority of the patients (58%) were male, married (66%) and employed (82%). Most of the patients were in the later diagnosis period (86%), and on ART (68%). Half of the patients (48%) were in the first stage of disease.

Of 50 patients, 14 (28%) had PD. The categorisation levels of no distress, moderate and severe PD are shown in Figure 2, in which severe distress was found among 12 (24%) of the patients. When spirituality score was calculated, 92% of the patients had a high spirituality score as seen in Figure 3. As shown in Table 2, among those who had a high spirituality score, 78.3% of the patients were not psychologically distressed, and it was revealed that there was a significant reduction in PD with higher spirituality (Chi-square = 13.77, $p < 0.001$). Table 3 shows the utilisation of spiritual coping methods versus PD. With high utilisation of personal spiritual coping methods, less PD was found among patients (Chi-square = 25.78, $p < 0.001$). High utilisation of corporate coping methods resulted in less PD (Chi-square = 17.07, $p < 0.001$).

Table 4 illustrates the association of demographic and clinical characteristics with PD. Analysing sex and PD, severe distress was found more in male patients (34.5%, $n = 10$) compared to female patients (9.5% $n = 2$) (Chi-square = 5.160, $p = 0.125$). Patients who were unemployed were found to be more severely distressed (33.3%), when compared to patients who were employed (22.0%) (Chi-

Table 1: Basic demographic and clinical characteristics of HIV patients (n=50).

S. No.	Demographic and clinical characteristics	Frequency	Percentage
1	Sex		
	Male	29	58
	Female	21	42
2	Marital status		
	Single	4	8
	Married	33	66
	Separated	1	2
	Divorced	2	4
	Widowed	10	20
3	Occupation		
	Employed	41	82
	Unemployed	9	18
4	Time of diagnosis		
	Early	7	14
	Late	43	86
5	Stage of disease		
	I	24	48
	II	6	12
	III	16	32
	IV	4	8
6	ART status		
	Yes	34	68
	No	16	32

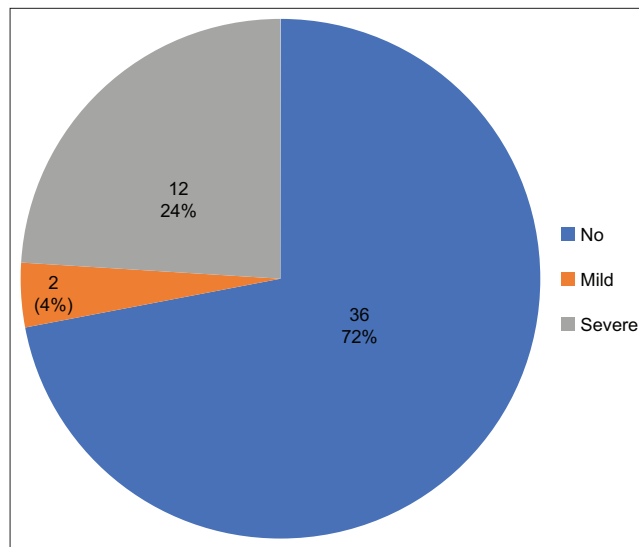
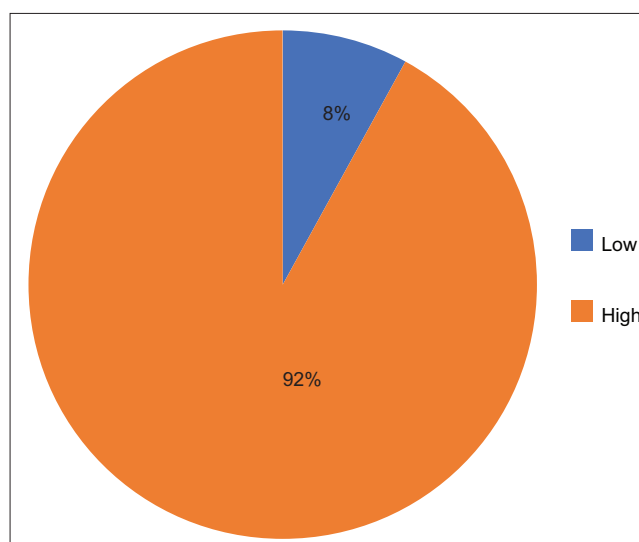
HIV: Human immunodeficiency virus, ART: Antiretroviral therapy

Table 2: Spirituality versus psychological distress.

Spirituality	No distress (%)	Yes distress (%)	X ² , p-value
High spirituality (n=46)	78.3	21.7	
Low spirituality (n=4)	0	100	13.77, 0.001

Statistically significant at: $p < 0.001$

square = 3.023 $p = 0.221$). Divorced (50%) and single (50%) patients were severely distressed when compared to those who were married (27.3%). Among the patients who were found to be severely distressed the number was more in the early diagnosis category (28.6%) than in the late diagnosis category (23.3%) (Chi-square = 0.397, $p = 0.820$). Patients who were in Stage 4 were found to be severely distressed (50%) compared to those in other stages (Chi-square = 5.527, $p = 0.478$). Patients who were not on ART were found to be severely distressed (37.5%) than patients who were on ART

**Figure 2:** Psychological distress in human immunodeficiency virus patients.**Figure 3:** Spirituality score of human immunodeficiency virus patients.

(17.6%) (Chi-square = 3.023, $p = 0.221$). Although there was an association found between all the characteristics and PD, it was not statistically significant.

Patients were asked about the importance of physicians to address spirituality as a coping method for PD and 86% of patients answered that it was very important for physicians to address spirituality as a coping method for PD, and 14% of patients answered that it was less important.

DISCUSSION

The present study aimed to identify the prevalence of PD among PLHIV, assess their spirituality and spiritual coping methods, and their association with the PD.

Table 3: Utilisation of personal and corporate spiritual coping methods versus psychological distress.

Coping methods	No distress (%)	Mild distress (%)	Severe distress (%)	X ² , p-value
Personal spiritual coping methods				25.775, 0.001
Low utilisation (n=7)			100, n=7	
High utilisation (n=43)	83.7, n=(36)	4.7, n=2	11.6, n=5	
Corporate spiritual coping methods				17.068, 0.001
Low utilisation (n=7)	14.3, n=1	0	85.7, n=6	
High utilisation (n=43)	81.4, n=35	4.6, n=2	14, n=6	

Statistically significant at: $p < 0.001$

Table 4: Association of demographic and clinical characteristics with psychological distress.

Characteristic	No distress (%)	Mild distress (%)	Severe distress (%)	X ² , p-value
Sex				
Male (n=29)	62.1, n=18	3.4, n=1	34.5, n=10	5.160, 0.125
Female (n=21)	85.7, n=18	4.8, n=1	9.5, n=2	
Occupation status				
Unemployed (n=9)	66.7, n=6	0	33.3, n=3	3.023, 0.221
Employed (n=41)	73.2, n=30	4.8, n=2	22.0, n=9	
Marital status				
Single (n=4)	50, n=2	0	50, n=2	
Married (n=33)	66.7, n=22	6.0, n=2	27.3, n=9	
Separated (n=1)	100, n=1	0	0	
Divorced (n=2)	50, n=1	0	50, n=1	
Widowed (n=10)	100, n=10	0	0	
Time of diagnosis				
Early (n=7)	71.4, n=5	0	28.6, n=2	0.397, 0.820
Late (n=43)	72.1, n=31	4.7, n=2	23.2, n=10	
Stage of disease				
Stage 1 (n=24)	75, n=18	0	25, n=6	5.527, 0.478
Stage 2 (n=6)	66.6, n=4	16.7, n=1	16.7, n=1	
Stage 3 (n=16)	75, n=12	6.2, n=1	18.8, n=3	
Stage 4 (n=4)	50, n=2	0	50, n=2	
ART status				
On ART (n=34)	76.5, n=26	5.9, n=2	17.6, n=6	3.023, 0.221
Not on ART (n=16)	62.5, n=10	0	37.5, n=6	

ART: Antiretroviral therapy, Statistically significant at: $p < 0.001$

PD is highly prevalent among PLHIV and is between 30.5% and 51%, which was reported in many studies from India, Western Europe, Canada, Spain, Ethiopia and Nigeria.^[5,8-13] A similar finding closer to the above studies is seen in the present study (28%). In contrast to the above findings, another study from Ethiopia reported a prevalence lower than that of the present study (17.42%).^[8] HIV/AIDS has a devastating effect on the physical and psychological well-being of PLHIV, and they go through severe physical suffering alongside severe PD, which is clearly seen from the above study findings from the literature.

This study reveals a higher spirituality score among 92% of participants, and patients with high spirituality scores show reduced PD. India, being a nation with high spiritual and religious beliefs, tends to value and utilise spirituality as a great support and coping with traumatic experiences. Religiosity and spirituality have been shown as significant coping strategies among PLHIV,^[20,21] which supported this study finding, in which utilisation of both personal and corporate spiritual coping methods resulted in decreased PD. Studies in Tanzania and Malaysia asserted that spirituality was positively related to active coping and PD.^[22,23] Confounding

variables such as socioeconomic background, family support and presence of preexisting mental health disorders might have influenced this finding inversely too. Patients with less PD may use more spiritual coping, which requires further investigation. High utilisation of personal and corporate spiritual coping methods resulted in less severe distress. Indians having high spiritual and religious beliefs resort to spiritual coping methods in times of physical and PD. When utilisation of spiritual coping methods reduce PD, reverse causality may also occur, as those who are less distressed may have more ability to engage in spiritual practices.

In the present study, majority of the subjects studied were male (58%), married (66%) and employed (82%), which is partially consistent with the demographic characteristics of a study done in Nigeria, about PD among PLHIV, in which 62% were females and 51% were married.^[14] In contrast to the above finding, a study done in Spain among male and female HIV patients found that 17.6% of them were women, which was less than the other study reports,^[11] including the present study finding.

Severe PD was seen more among males (34.5%) in this study. This was not the same in other studies. A study in Ethiopia reported that psychological stress was observed more among females.^[9] A similar finding is reported in a study done in Spain revealing that more than half of the women were in PD, whereas a third of the men were in PD.^[11] The PD among HIV males seems to be higher in India, where majority of the males are breadwinners, who are expected to carry family, economic and social burdens.

Female gender, marital status, occupational status, time of diagnosis, stage of disease and ART status in the present study showed an association with PD, but it was not significant. The association did not show a significant result, probably because the sample size was not adequate for group comparison. The psychological stress was higher among patients who were in Stage 4, not on ART, and in the early diagnosis category. Patients on Stage 4, having severe symptoms and complications, undergo physical distress alongside emotional distress. Those who were not on ART were from the infectious disease clinic in the early diagnosis period. During the first 6 months, they go through an initial period of grief, non-acceptance of the disease, guilt feelings and physical suffering, and hence, the psychological stress may be more. For the patients from the ART clinic, who were started on ART, with better relief of symptoms and acceptance through counselling and treatment, the psychological stress might have been less. These findings are consistent with other studies, in which female gender, occupational status, living alone, marital status, stage of disease and ART status were associated with PD.^[5,11]

Strengths of the study

The study data were collected exclusively by the investigator, subjectivity that could have arisen due to self-reporting was

avoided. Spirituality, being a sensitive concern for PLHIV, was explored with accuracy as privacy was maintained during data collection. Those patients identified to have severe PD were helped to receive further guidance and counselling.

Implications

This study enhances the understanding of PD in PLHIV, spirituality and utilisation of spiritual coping methods. Further, it helps to advance the understanding of various demographic and clinical factors that are associated with it. The assessment of psychological stress in ART clinics and other clinics, where PLHIV visit for treatment and follow-up, can become part of the routine assessment to identify PD. Spiritual interventions that have been helpful to reduce PD in this study could be recommended to patients, and they can be encouraged to choose interventions according to their preferences. Healthcare providers must be vigilant in identifying the levels of PD and provide timely interventions to prevent prolonged psychological suffering, particularly among PLHIV. Similar disease conditions that produce PD can also be screened as a routine for identification and initiating effective interventions. PD screening can be taught to students of all healthcare disciplines, and they can be involved in identifying PD among PLHIV.

Limitations and recommendations

While the study provides valuable insights, it also has many limitations. The small sample size and specific geographic region could limit the generalisability of the findings. Although few demographic and clinical factors were studied, other confounding factors such as socioeconomic status of the patients, pre-existing mental health disorders, presence of comorbid conditions, sociocultural factors and family support were not explored in this study. Future studies could explore other confounding variables using a large sample size. To get a comprehensive understanding of the psychological well-being and distress, longitudinal studies could be undertaken. The present study could be expanded to include diverse populations and multiple geographic regions to enhance the generalisability.

CONCLUSION

Spirituality is a very sensitive concern to patients in general, but more so among PLHIV, and studies are scarce in this area. When the patients' opinion was questioned, 80% of the patients expressed that it was important for physicians to address spirituality as a protective coping method for PD. Healthcare providers need to be aware of the psychological and spiritual needs of PLHIV and address them as a part of HIV care. Recognising the presence of PD and enhancing appropriate interventions will promote better psychological well-being and quality of life of PLHIV. Spiritual coping strategies can be focused on during the counselling with

sensitive consideration of the individual differences and preferences.

Ethical approval: The research/study was approved by the Institutional Review Board at IRB Christian Medical College Vellore, approval number 6971, dated 21st October 2009.

Declaration of patient consent: The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given consent for clinical information to be reported in the journal. The patient understands that the patient's names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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